Patient Information

☐ Patient holds Insurance ☐Someone else holds insurance
☐Guarantor holds insurance ☐No Insurance

☐New Patient ☐Established Patient

Full name:

Date of Birth: Gender: ☐Male ☐Female

Social Security #:

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Race: ☐American Indian ☐ African American ☐White ☐Asian
☐Hawaiian Native ☐Other Race ☐Decline

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/ non-Latino

Mailing Address:

City: State: Zip:

Preferred Phone #: ☐Home ☐Cell ☐Work

Secondary Phone #: ☐Home ☐Cell ☐Work

Email:

Emergency Contact: Phone #:
Relationship:

May we release medical and financial information to your Emergency Contact? ☐ Yes ☐ No

If no, who may we release information to?
Name: Phone Number: Relationship:

Who is your Primary Care provider?

Preferred Pharmacy:

Do you authorize us to check your medication history? ☐Yes ☐No

Guarantor and Insurance Holder Information

Guarantor	**Insurance holder**
Full name:	Full name:
Date of Birth:	Date of Birth:
Social Security #	Social Security #
Relationship:	Relationship:
Mailing address: City: State: Zip:	Mailing address: City: State: Zip:
Preferred Phone #: ☐Home ☐Cell ☐Work	Preferred Phone #: ☐Home ☐Cell ☐Work

Medical Information

Visit Reason: Date: ___ / ___ / ___

Allergies:

Medical Problems:

Surgical History:

Current Medications:

Cedars Health contracts third party physicians to review visit notes for state compliance and quality control. Your visit may be randomly selected for review.

I consent to a possible review of my visit notes: ☐Yes ☐No

Notify me if I am randomly selected: ☐Yes ☐No

Signature: **(REVIEW DISCLOSURES, CONSENTS AND POLICUES ON THE BACK BEFORE SIGNING)**

By signing here, you certify that this information in correct and valid and agree to the IMPORTANT DISCLOSURES, CONSENTS AND POLICIES ON BACK

DISCLOSURES

I give permission to this office, its service providers, collection agencies, successors and assigns to dial (including auto dialed calls) any phone number (including cell phones) provided by or otherwise owned by me or my spouse.

I give permission to this office, its service providers, collection agencies, successors and assigns to leave a message (including automated messages) on the voicemail of any phone number (including cell phones) provided by or otherwise owned by me or my spouse which may include the name of the company dialing the call.

I give permission to this office, its service providers, collection agencies, successors and assigns to communicate with me by email at any email address provided by me or my spouse regarding services provided and my financial obligations regarding those services.

CONSENT TO TREAT

I consent to the use or disclosure of my protected health information by CEDARS HEALTH for the purpose of diagnosing or providing treatment to me, obtaining payment or to conduct health care operations of CEDARS HEALTH. I understand that CEDARS HEALTH may request and obtain medical records, pharmacy records and/or dental records in my treatment. I understand diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. CEDARS HEALTH is not required to agree to the restrictions that I may request. However, if CEDARS HEALTH agrees to a restriction that I request, the restriction is binding on CEDARS HEALTH.

I have the right to revoke this consent, in writing, at any time, except to the extent that CEDARS HEALTH has acted in reliance on this consent.

PAYMENT POLICY

1. Insurance. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit may be required. Knowing your insurance benefits is your responsibility. By signing this form, you authorize Cedars Health, LLC to release the necessary information in order to complete and process your insurance claims.

2. Workers Compensation. You are required provide your case number. If your Workers Compensation claim is denied, payment is your responsibility.

3. Co-Payments and deductibles. All co-payments, co-insurance, and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

4. Non-covered services. Some and perhaps all the services received may not be covered by your and will become your financial responsibility.

6. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply in a timely manner with their request. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

7. Coverage Changes. If your insurance changes, please notify us as soon as possible so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will be billed to you.

8. Non-Payment. If you have not made payments to your account and if there has been no attempt to contact our office with financial arrangements, it may be assigned to a collection agency after 90 days of no payment on account.

10. Returned checks (NSF). You will be charged a $30.00 processing fee for any personal check returned for nonpayment.

11. No Show Policy. Out of courtesy for our patients and staff, if you do not cancel your scheduled appointment within 24 hours of the appointment time, it is at Cedars Health's discretion to charge a "no show fee". This is subject to extenuating circumstances and it is also understood that accidents happen.

PRIVACY POLICY

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer, or a healthcare clearing house. This protected information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review CEDARS HEALTH Privacy Policy (HIPPA) prior to signing this document. CEDARS HEALTH Privacy Policy has been provided to me. The Privacy Policy describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment or in the performance of the health care operations

of CEDARS HEALTH. The Privacy Policy for CEDARS HEALTH is held at the reception desk. This Privacy Policy also describes my rights and CEDARS HEALTH'S duties with respect to my protected health information.

CEDARS HEALTH reserves the right to change the privacy practices that are described in the Privacy Policy. I may obtain a revised notice of privacy practices by contacting CEDARS HEALTH and requesting a revised copy be sent in the mail or asking the receptionist for a revised copy at my next appointment.