

**The Narrows Health & Wellness
Patient Demographic & Insurance Information**

Basic Patient Information

Patient's Social Security Number: _____ Gender: F M Date: _____

Name of Patient: _____
First Middle Last

Birth Date: _____ Drivers' License & State: _____ Email Address: _____

Mailing Address: _____

Physical Address (if different from above): _____

City: _____ State: _____ Zip: _____

Cell Phone: () _____ Work Phone: () _____ Home Phone: () _____

Billing Information/Responsible Party/Guarantor for Encounter

Responsible Party: _____
 (Person with patient if patient is under 18) First Middle Last

Mailing Address: _____

City: _____ State: _____ Zip: _____ DL Number & State: _____

Birth date: _____ Responsible Party's SSN: _____ Gender: F M

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Responsible Party's Employer: _____

Insurance Coverage Primary

Please present your insurance card & drivers license to the front desk receptionist when returning this form

Name of Insurance: _____ Policy Number: _____

Group Name: _____ Effective Date: (if applicable) _____

Co-Pay Amount: _____ Group Number: _____

Patient's Relationship to Policyholder Self Child Spouse Guardian Other

Name of Policyholder: _____
(If different from Responsible Party) First Middle Last

Birth Date of Policyholder: _____ Phone: () _____ Gender: F M

Name of Policyholder's Employer: _____

Address of Insurance Holder: _____
(If different than Responsible Party Information)
 City: _____ State: _____ Zip: _____

Insurance Coverage - Secondary

Name of Secondary Insurance: _____
Policy Number: _____ Group Number: _____ Effective Date: _____

Patient's Relationship to Policyholder: Self Child Spouse Guardian Other

Name of Policyholder: _____
First Middle Last

Birth Date: _____ Phone: () _____ Gender: F M

Name of Policyholder's Employer: _____

Address of Insurance Holder: _____
(If different than Responsible Party Information) City: _____ State: _____ Zip: _____

Emergency Contact Information

Name: _____ Relationship to Patient: _____

Home Phone: () _____ Work / Cell Phone: () _____

Street Address: _____

City: _____ State: _____ Zip: _____

Financial Responsibility Agreement

I/We hereby authorize The Narrows Health and Wellness to furnish all information regarding my medical history, diagnosis and treatment of myself or my child (if applicable) to an insurance company regarding my claims for benefits. If however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I/We agree to be responsible for the fee and cost involved in the treatment of the above named patient. I understand that Narrows Health & Wellness do not accept assignment for Medicaid payments and I am responsible for payment of services rendered. I/We authorize payment of medical benefits to The Narrows Health and Wellness and further understand that should my account have to be referred to collections, I am responsible for all fees and costs incurred therein. I/We hereby authorize The Narrows Health and Wellness to act on my behalf in accessing hospital records when and if needed.

_____ Date

_____ Patient or Guardian Signature

Date: _____

Patient Name: _____ New Patient Existing Patient

Chief Complaint for Today's Visit: What When Where Why How Long

Patient Social History

Marital Status: Single Married Divorced Separated Widowed

Years education completed: _____ Native Language: _____ Race: _____

Occupation: _____ Religion: _____

Consumption: _____ Caffeine _____ Tobacco _____ Alcohol _____ Recreational Drugs

Military / Travel History: _____

Please check if you are currently receiving treatment or have received treatment in the past for any of the following conditions:

<u>Condition</u>	<u>Self</u>	<u>Family Member</u>	<u>Condition</u>	<u>Self</u>	<u>Family Member</u>
Abdominal Adhesions	_____	_____	Gallbladder Disease	_____	_____
Anemia / Bleeding Disorder	_____	_____	Headaches	_____	_____
Asthma / COPD	_____	_____	Hepatitis / HIV	_____	_____
Backache / Spine Problems	_____	_____	Hypertension	_____	_____
Bone / Joint Problems	_____	_____	Irritable Bowel Syndrome	_____	_____
Breast Lump or Mass	_____	_____	Lupus / Arthritis	_____	_____
Cirrhosis / Pancreatitis	_____	_____	Mental illness / Alcoholism	_____	_____
Constipation / Diarrhea	_____	_____	Pneumonia / TB	_____	_____
Coronary Artery Disease	_____	_____	Reflux / Gastritis / Ulcer	_____	_____
Crohn's / Colitis / Diverticulitis	_____	_____	Sleep Disorders	_____	_____
Diabetes / Thyroid Disorders	_____	_____	TIA / Stroke	_____	_____
Early Death / Heart Attack	_____	_____	UTI / Kidney Stones	_____	_____
Endometriosis / Fibroids	_____	_____			

Cancer / Colon Polyps Type & Location: _____ Self _____ Family Member _____

Motor Vehicle Accident with Injuries: _____

Other (Please Specify) _____

Allergies: (Circle any that apply) Penicillin Sulfa Cephalosporin Seasonal Aspirin Other _____

Please list all previous operations

<u>Surgery / Orthopedic / Date</u>	<u>Current Prescriptions / Over the Counter Medications</u>
_____	_____
_____	_____
_____	_____
_____	_____

Narrows Health & Wellness Office Payment Policies

New Patients

- o New patients are required to have their picture identification and / or insurance cards
- o If you do not have your insurance card, you will have to pay full price unless we can verify your insurance
- o We do not bill for co-pays or office visits
- o We do bill for deductible balances as indicated by your insurance
- o Fill out your paperwork using the name as it appears on your insurance card

Established Patients

- o Please sign in using your given name
- o Co-pays and office visits are due at the time of sign in
- o If you have a balance, it is due with your co-pay and office visit at the time of your visit
- o If your insurance changes, you will be responsible for getting us a corrected copy of your insurance card

Responsible Parties

- o If you are over the age of 18, you are responsible for your own account
- o The parent that comes in with children under the age of 18 will be responsible for the account. We cannot bill a parent who does not bring the child in to be seen

Insurance

- o We file insurance as a courtesy to our patients. **If you have a deductible that has not been met and/or your insurance does not pay, you are responsible for the balance at the time of service.**
- o Your insurance is your responsibility, your account is also your responsibility

Billing

- o We will bill for account balances
- o If your account is not paid within a timely manner, we will send your account to our attorney / collection company for processing
- o If your account goes to our attorney / collection company, you will be responsible for any additional fees
- o Returned check fee \$30 per check

Patient / Parent / Guardian Signature

Date

CONSENT FOR THE USE AND DISCLOSURE OF PHI -- PROTECTED HEALTH INFORMATION

By signing below, you consent to the use and disclosure of your protected health information by Narrows Health and Wellness, our staff, and our business associates for treatment, payment and health care operations. For more detailed description of the uses and disclosures for these purposes, please review our **Notice of Privacy Practices**. You have the right to review our **NOTICE** prior to signing this consent and to request a copy of the **NOTICE**. As we reserve the right to change or update the **NOTICE**, we will post any future revisions as they occur for your records. You have the right to restrict our uses or disclosures of your protected health information which we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to the requested restrictions. However, if Narrows Health and Wellness agrees to further requested restrictions, they are binding on us. Finally you have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on it.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY

We are required by law to use reasonable efforts to maintain the privacy of, and provide individuals with, the posted **Notice of Privacy Practices**. It stipulates our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. By signing below, you acknowledge that you have received this notification and been informed of your privacy rights.

I AGREE AND ACKNOWLEDGE:

Signature of patient or Legal Representative

Printed name of patient or Legal Representative

Date signed

Office use only
