



Close to home. Care you can trust.

Date: \_\_\_\_\_

Social Security # of Patient: \_\_\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Sex: M ( ) F ( )

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home No.: (\_\_\_\_\_) \_\_\_\_\_ Work No.: (\_\_\_\_\_) \_\_\_\_\_ Cell No.: (\_\_\_\_\_) \_\_\_\_\_

Email address: \_\_\_\_\_ ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed

Patient's Physician \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

\* For your convenience, if you would like Care United to forward medical records to your physician please ask the staff for a "Medical Records Release" form.

What are we seeing you for today? \_\_\_\_\_

Are we seeing you today due to a motor vehicle collision? \_\_\_\_\_ If yes, was it within the last 24 hours? \_\_\_\_\_

If you answered YES to both the above questions STOP and advise the front desk personnel.

How did you hear about us? Please circle one.

Doctor Referral / Friend / Internet / Mailer /Phone Book / Signage / Work / Other \_\_\_\_\_

**RESPONSIBLE PARTY (if same as PATIENT, please put "SAME" on Guarantor line)**

Guarantor Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address City/State/ Zip \_\_\_\_\_

Home No.: (\_\_\_\_\_) \_\_\_\_\_ Work No.: (\_\_\_\_\_) \_\_\_\_\_ Cell No.: (\_\_\_\_\_) \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Sex: M ( ) F ( )

If patient is a minor, whom does the patient reside with? \_\_\_\_\_

Employer \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

**FOR PATIENTS WITH INSURANCE**

Primary Insured Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer Name: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Insurance Co. Phone No.: \_\_\_\_\_

Insurance Company Address City/State/Zip: \_\_\_\_\_

Plan or Group # \_\_\_\_\_ Insured Id. No.: \_\_\_\_\_

**LIFETIME AUTHORIZATION INSURANCE ASSIGNMENTS  
AND AUTHORIZATION TO RELEASE INFORMATION**

I. **RELEASE OF INFORMATION** - I, the below mentioned patient, authorize Care United Medical Centers of America to release to any third party payer or consulting physician any medical records concerning diagnosis and treatment when requested for its use in connection with determining payment for services rendered and/or further treatment and/or diagnosis.

II **PHYSICIAN INSURANCE ASSIGNMENT** - I, the below named subscriber, authorize payment directly to Care United Medical Centers of America for its services as described but not to exceed the reasonable and customary charge for these services. **I understand that my insurance \_\_\_\_\_ may/or may not be in network with Care United Medical Centers of America and/or the physicians providing service.** I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third party payer within a reasonable period of time not to exceed 60 days.

III **MEDICARE PATIENTS ONLY** – I, the below mentioned patient, understand my signature requests that payment be made directly to Care United Medical Centers of America and authorizes release of medical information to the centers for Medicare and Medicaid Services (CMS) and its agents. In Medicare assigned cases, the physician agrees to accept the allowed charge determination of the Medicare carrier and the patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are the determination of the Medicare carrier.

IV. I, PERMIT A PHOTO COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT CARE UNITED MEDICAL CENTERS OF AMERICA’S OFFICE. **This assignment will remain in effect until revoked by me in writing.**

I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid by my insurance or third party payer. Should your check for payment be returned for any reason, we will assess a \$25.00 return check fee to your account. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. A \$25.00 fee will be added to your account if it is sent to collections.

Date \_\_\_\_\_ Signature: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Parent or Legal Guardian \_\_\_\_\_

**ACKNOWLEDGEMENT OF REVIEW OF PRIVACY PRACTICES**

**(please see attached)**

I have been offered and/or reviewed this office’s Notice of Privacy Practices, which explains how my medical information will be disclosed. I understand I am entitled to receive a copy of this document.

\_\_\_\_\_

\_\_\_\_\_

Signature of Patient or Personal Representative

Date