FAMILY HEALTH ASSOCIATES
Patient Information

Date ___________________________

Patient ____ **Birthdate**: ________________
Last Name First Name Middle Initial

Street Address ________________________ **City** _____________________ **State** ________ **Zip Code** __________

Mailing Address _______________________ **City** _____________________ **State** ________ **Zip Code** __________

Social Security # _________________ **Email address**: _________________________________

Gender Identity: Male Female Transgender Male Transgender Female
Neither Male or Female Other Declined

Sexual Orientation: Straight Gay Lesbian Bisexual Other Unknown Declined **Marital**

Status: Single Married Divorced Widowed

Race: Asian Black/African American Caucasian/White American Indian/Alaskan Native
Native Hawaiian/Pacific Islander Unknown

Ethnicity: Hispanic/Latino Not Hispanic or Latino **Preferred Language:** ____________________

Home Phone # ___________________ **Cell Phone #** ____________________ **Work Phone #** _________________

Which is your preferred phone? Home Cell Work **Preferred contact?** Voice Email Text None

Employed by _________________________________

In case of emergency, who should be notified _______________________ **Relationship** _________ **Phone #** _______

Second contact person __________________________ **Relationship** _______________ **Phone #** _______________

Who is responsible for this account? __________________________________ Relationship to patient ______________

Mailing Address ________________________ City _____________________ State ________ Zip Code __________

Home Phone # ___________________ Cell Phone # _____________________ Work Phone # ___________________

Social Security # _____________ Birthdate ______________ Male Female Employed by ____________

Name of primary Insurance Company _______________________ Employer: _______________________________

Subscriber Name _________________________________ SS # _____________________ DOB _________________

Name of secondary Insurance Company _________________ Subscriber Name: __________________DOB________

Do you have Medicare? Yes No Medicare # ______________ Medicare Part D Provider _________________

Name of Preferred Pharmacy __________________________ City: ____

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Date ___________________________

Patient ____ **Birthdate**: ________________
Last Name First Name Middle Initial

Authorization for Treatment

By signing below I am allowing Family Health Associates (FHA) to provide health care related treatment and consultation to the previously-named patient and that I may refuse treatment or services at any time. I understand FHA does not guarantee any outcome for any services or treatment either stated or implied.

Signed __________________________________ Date ____________ Relationship to patient _____________________

Assignment, Release and Authorize

I, assign directly to Family Health Associates, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signed __________________________________ Date ____________ Relationship to patient _____________________

HIPAA (Health Insurance Portability and Accountability Act)

I understand that I have the right to receive and review a written description of how Family Health Associates will handle my health information. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Family Health Associates and my right regarding my health information.
I understand that the **Notice of Privacy Practices** may be revised from time to time, and that I am entitled to receive a copy of any revised **Notice of Privacy Practices**. I also understand that a copy or summary of the most current version of Family Health Associates' **Notice of Privacy Practices** in effect will be posted in the waiting/reception area.

Signed __________________________________ Date ____________ Relationship to patient _____________________

Permissions (these permissions will stay in effect until changed by patient or parent/guardian)

I give my permission for FHA to speak with and/or leave messages with regarding treatment, billing and/or appointment status (name of each person and relationship to patient)

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Signed __________________________________ Date ____________ Relationship to patient _____________________