

Rockbridge Family Medicine

Patient Name:

Last

First

Middle Initial

Address:

Street & Apt #

City

State

Zip Code

Date of Birth:

SS#:

Sex F M

Marital Status S M W D

Employer:

Occupation:

*****PLEASE INDICATE THE NUMBER WHERE WE CAN LEAVE DETAILED AND PRIVATE INFORMATION*****

Circle the best day time number

Home #:

Work #:

Cell#:

Emergency Contact:

Phone #:

Cell #:

If you wish for your spouse, parent, etc. to receive results or information on your behalf you **MUST** complete this section

I give permission for (name)

(relationship to patient)

(dob)

(phone #) ()

to receive results or information on my behalf.

Person responsible for this account **if other than self or if the patient is a minor.**

Name:

Relationship:

Address:

Home Phone:

Wk Phone:

Cell Phone:

Employer :

Occupation:

Insurance Information

Primary Insurance Company:

ID#:

Name of Policy Holder:

(person whose work insurance is through)

SS#:

DOB:

Relationship:

Secondary Insurance Co.:

ID #:

Name of Policy Holder:

(person whose work insurance is through)

SS#:

DOB:

Relationship:

It is the policy of this office that payment is the responsibility of the patient and payment be made at the time services are rendered. However, we will file your claim if we are a participant on your insurance. I give my permission for all providers with Rockbridge Family Medicine to treat the patient above. The above informations is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my provider or any member of his/her staff responsible for errors or omissions that I may have made in the completion of this form. I authorize any holder of medical or other information about me to release to my insurance company or to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to my physician. Regulations pertaining to medical assignment of benefits apply. I understand that I am financially responsible to the physician for charges not covered by this agreement or that which is above the usual and customary determined by my insurance company.

I UNDERSTAND THAT ROCKBRIDGE FAMILY MEDICINE IS HIPAA COMPLIANT. I HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW THE HIPAA PRIVACY POLICIES.

Signed:

Date: