INITIAL POINT | FAMILY MEDICINE

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PATIENT INFORMATION SHEET

Patient Name:____Date: ____________________
First Middle Last

Mailing Address:_____________________________________City/State/Zip: __________________________

Primary Telephone: ( )______________________Secondary Telephone: ( ) _________________________

Birth Date:________________Race:_____________Ethnicity:__________ Language:______________________

Occupation:__________________________________Employer: ______________________________________

Work Phone: ( )_____________How did you hear about our office?_________________________________

Preferred Pharmacy:____________________________Location:_______________________________________

We recommend you sign up for the Patient Portal to view labs, statements, etc. online, would you like to sign up? (Must be at least 18 years old) Yes___ No___ E-mail: ____

How do you prefer to be notified of lab results (i.e. phone call, mail, patient portal)?________________________

Emergency Contact: _____________________Phone:__________________Relationship:_________________

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I give permission for Initial Point Family Medicine to provide any information about my medical condition, medical needs, medications or the status of my account to the following individual(s):

Name of Designated person: ________________________Relationship:__________Phone:__________________

Name of Designated person: ________________________Relationship:__________Phone:__________________

☐ I decline any release of information (This does not apply to covered entities listed in the HIPAA rules at 45 CFR 160.103)

Complete this section only if someone other than patient is financially responsible

Responsible Party:_________________________________Relationship to patient: _______________________

Mailing address:____City/State/Zip: ________________________

Primary Telephone: ( )______________________Birth Date: _________________________

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember you are responsible for all deductible, co pay and non-covered service amounts. See our complete financial policy for details.

Patient Signature (or guardian if under 18)_____________________________________Date: _______________

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to the Patient:

Initial Point Family Medicine, PLLC ("Practice") is required to provide you with a copy of our Notice of Privacy Practices, which states how the Private Practice may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of the Practice's Notice of Privacy Practices.

Patient's name (please print): ____________________________

Signature: ____

Date: ___________________________

FOR OFFICE USE ONLY

The Practice made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices from the Patient but it could not be obtained because:

☐ The Patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgment.

☐ The Practice was unable to communicate with the Patient.

☐ Other: ____