

# ProHealth Partners Patient Information Sheet

## PATIENT INFORMATION *(please print)*

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

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

Billing Address (if different) \_\_\_\_\_

Work Address (if different) \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Preferred Contact # \_\_\_\_\_ Email Address \_\_\_\_\_

Drivers License # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Sex:    M    F Marital Status:  S  M  D  W  Other \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Primary Language \_\_\_\_\_

Race \_\_\_\_\_ Ethnicity (*circle one*)  Hispanic or Latino  Not Hispanic or Latino

Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

### GUARANTOR/PARENT/INSURED INFO [SEND BILL TO]:

Guardian Last Name (if applicable) \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Relationship \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ DOB \_\_\_\_\_ Social Security # \_\_\_\_\_

Billing Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Group or Policy # \_\_\_\_\_ Cert. or Member # \_\_\_\_\_ Local Union # \_\_\_\_\_

Co-pay Amount \_\_\_\_\_ Policy Effective Dates: From: \_\_\_\_\_ To: \_\_\_\_\_

Patient Relation to Policy Holder:  Self  Spouse  Child  Other: \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ DOB \_\_\_\_\_ Social Security # \_\_\_\_\_

Billing Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Group or Policy # \_\_\_\_\_ Cert. or Member # \_\_\_\_\_ Local Union # \_\_\_\_\_

Co-pay Amount \_\_\_\_\_ Policy Effective Dates: From: \_\_\_\_\_ To: \_\_\_\_\_

Patient Relation to Policy Holder:  Self  Spouse  Child  Other: \_\_\_\_\_

## PHARMACY INFORMATION

Pharmacy Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature (Patient or Parent of Minor): \_\_\_\_\_ Date: \_\_\_\_\_



**FINANCIAL POLICY**

**AGREEMENT TO PAYMENT POLICY** I acknowledge that I received a copy of PROHEALTH PARTNERS, INC., financial policy and agree to the terms of payment due.

**AUTHORIZATION TO RELEASE INFORMATION** I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to PROHEALTH PARTNERS, INC., any and all of my medical records information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

**ASSIGNMENT OF BENEFITS** I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to PROHEALTH PARTNERS, INC., for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

**GUARANTEE OF PAYMENT** I agree to pay all applicable charges, which are not paid in full by my insurance. If amounts due to PROHEALTH PARTNERS, INC., are not paid according to this financial policy, the account shall be deemed delinquent. In the event that I default on payment of my account, I understand I am responsible for any and all cost incurred on the collection of my account, including court cost and reasonable attorney's fee. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

Patient's Signature Date

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Responsible Party Relationship to Patient

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