New Patient Information and Consent

What is the reason for your visit today?

Patient Information

Name (First, Middle, Last)		Date of Birth	Age	Social Security #	Birth Gender ☐ M ☐ F
Mailing Address	Apt #	City, State ZIP			
Email Address		Primary Phone ☐ Home ☐ Cell	Okay to leave message? ☐ Yes ☐ No		
Primary Care Provider (where you go for your routine medical care)		☐ None ☐ Doctors Care is my primary care provider			
Preferred Language		Race ☐ Black or African American ☐ Asian ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ American Indian/Alaska Native ☐ Prefer not to answer			
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino					

Emergency Contact

Contact Name	Phone Number	Relationship to Patient

Guarantor/Responsible Party (person responsible for payment)

Legal Name of Responsible Party (First, Middle, Last)	Social Security #
Email Address (if different from the patient email above)	Date of Birth

Preferred Pharmacy

Pharmacy Name	Pharmacy Location

Medical Insurance (please present your ID and insurance card to the receptionist)

PRIMARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (usually on back of insurance card)		Phone

SECONDARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (usually on back of insurance card)		Phone

Please continue to the next page.

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CONSENT FOR TREATMENT: I hereby voluntarily consent to care, treatment, testing and all other services performed by healthcare providers at Pioneer Family Medicine & Urgent Care. At the same time, I do understand that I have the right to refuse consent to any proposed care, treatment, testing, surgery, or procedure. Moreover, I have the right to ask questions and discuss my concerns with my healthcare provider. I am aware that the practice of medicine and surgery is not an exact science. I understand that diagnosis and treatment may cause injury or even death. I acknowledge that no guarantees have been made to me as to the outcome of my care, examination and; or treatment at Pioneer Family Medicine & Urgent Care. While I understand that I am required to sign this consent annually or as necessary, I may revoke this consent at any time my writing to the Pioneer Family Medicine & Urgent Care Release of Information Dept., PO BOX 994, Nortonville, KY 42442..

RELEASE OF MEDICAL INFORMATION: I understand that Pioneer Family Medicine & Urgent Care shall maintain both electronic and paper based documentation of the medical care received. This medical record will typically include individually identifiable information about my symptoms and health condition; results of physical examination and diagnostic tests; a plan regarding future care and treatment; as well as demographic and photographic identifiers. Such information about me is protected health information (PHI) and, as such, will be used, shared or disclosed only for the purpose of treatment, payment, and healthcare operations. Otherwise, it will not be inspected or released without my specific authorization except in certain circumstances outlined in the **Notice of Privacy Practices**.

Additionally, I am aware that data and information concerning essential medical treatment and healthcare services rendered on my behalf may be released, when necessary, to healthcare providers in emergent situations and/or to public and private health insurance plans in order to receive payment as outlined in the Pioneer Family Medicine & Urgent Care Financial Policy. However, I may request that PHI associated with that portion of my healthcare at Pioneer Family Medicine & Urgent Care, for which I paid out-of-pocket, not be disclosed to my health plan or insurance company. I understand that this request must be in writing.

A copy of the Notice of Privacy Practices is posted openly in both English and Spanish within the facility, and a paper copy is available at each registration desk.

PATIENT RIGHTS & RESPONSIBILITIES: I acknowledge that my healthcare is a partnership between Pioneer Family Medicine & Urgent Care and me; hence, I agree to actively participate and accept both my role and responsibility in reference to my healthcare and the rights available to me. A list of patient rights and responsibilities is posted in both Spanish and English within the facility. A copy of this is available upon request.

ADVANCE DIRECTIVES: Adults 1 8 and older have the right either (a) to give directions about their future medical care or (b) to designate patient representatives to make medical decisions for them if they lose individual decision-making capacity. I understand that information about advance directives is available to me upon request.

ATTESTATION: I have read and now fully understand the content of this consent form and its entirety, and all of my questions have been answered to my satisfaction.

ASSIGMENT & RELEASE: I hereby authorize my insurance benefits to be paid directly to the physicians and I am financially responsible for non-covered services. I also authorize the physician to release information required in the processing of this claim and all future claims. If any account is sent to a collection agency, I agree to pay all collection and attorney fees.

PATIENT SIGNATURE _____ **DATE:** _____

PATIENT PRINTED SIGNATURE _____