Capital Primary Care

Patient Information

Date: ______________ Home Phone#______________________

Cell Phone #: ______________________

Name: ____
(Last) (First) (Middle)

Soc.Sec.#: ___________________

Date of Birth: ________________ Age: ______ Sex (please circle one): M F

Address: ____ City: ____________________________________

State: ____ Zip: ____________________________________

Whom may we thank for referring you? ____

Emergency Contact Person. ____
(Name) (Phone)

EMPLOYMENT INFORMATION

Patient Employed by _______________________________ Occupation: ______________________________

Business address: __________________________________ Bus: Phone: ______________________________

INSURANCE INFORMATION

Person responsible for the account ____

Phone#: _______________________________

Primary Insurance_______________________________ Id#: ______________________________

Group# _________________

Other dependents on the plan ____

Secondary Insurance_________________________ Phone#: ______________________________

Group# _________________ Id#: ______________________________

Other dependents on the plan ____

Tertiary Insurance _____________________________ Phone#: ______________________________

Group# ___________________ Id#: _____________________________

Other dependents on the plan ____

In case of necessity I _________________________ authorize Capital Primary Care to release my PHI (Protected Health Information) to Medical facilities and to my insurance company to process claims.

By signing this form I _________________________, giving authorization to use my name, address and phone number for appointment reminders, and to call my name out loud while I am in the waiting room.

Signature___________________________ Date ________________

Authorization for Healthcare and Appointment Reminders and Permission to Say Your Name

Capital Primary Care and staff members of the practice may need to use your name, address, and phone number to contact you with appointment reminders and health related information to your interest.

- ❖ We will call you by name when it is time for your appointment.
- ❖ We may call your name out loud to receive information while you are in the waiting room.
- ❖ We may leave a message on your answering machine in the case of your absence. Such information may be subject to re-disclosure and may no longer be protected by privacy policies.

By signing this form, you are giving us authorization to say your name and to contact you with reminders and information.

You may restrict the individuals or organization to whom your health information is released, or you may revoke your authorization at any time. The request for revocation will have to be given to us in writing. Any information released prior to receiving the request for revocation cannot be contested.

In addition, if you were required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have the right to refuse authorization, your refusal will not affect the treatment we provide, or the methods used to obtain reimbursement for your care.

- I ______________________________ have carefully read the above and hereby
  □DO □DO NOT
  authorize **Capital Primary Care** to say my name and disclose health information in the manner described above.

______________________________ ______________________

Patient Signature (Parent if minor) Date

Capital Primary Care Service Coverage and Payment Agreement

I____ hereby authorize Capital Primary Care to perform medical and laboratory services.

I also agree that all my insurance benefits and hereby assigned to Capital Primary Care. Any portion of the bill unpaid is my responsibility.

I understand,

- All co-pays, deductibles, outstanding balances, and out to network payments are to be paid at the time of check in.
- Any fees of costs not paid at the time of service within 14 days of receipt of bill.
- Any bill unpaid after 30 days will be subject to beat bear interest at the highest rate authorized by law in the state of North Carolina.
- All returned checks will be charged of $25.00.
- Any service not covered by the insurance company is my responsibility.
- Prescriptions and Refills take 24 hours to process.
- Doctors may return calls up to 24 hours.

I have carefully read above statements and am in complete understanding of them.

____________________________ ____________________________

Patient Signature (Parent if minor) Date