

## PATIENT INFORMATION SHEET

We are in the process of updating and switching to a new office software program in order to come into compliance with the new rules and regulations that have been passed by the Government. We will need more detailed information on each patient, as the new operating system will **require** it to file your insurance. Thank you for your patience while we go thru this update. **There is a front and back to this form, please remember to complete both sides.**

LAST NAME	FIRST NAME	MIDDLE INITIAL	PATIENT'S NICKNAME
DATE OF BIRTH	PATIENT'S GENDER – CIRCLE ONE		PATIENT'S MARITAL STATUS – CIRCLE ONE
	FEMALE	MALE	SINGLE      MARRIED      OTHER
PATIENT'S EMPLOYMENT STATS – CIRCLE ONE		PATIENT REFERRED BY – IF REFERRED BY A DOCTOR – NAME & PHONE NUMBER	
EMPLOYED	STUDENT		
ADDRESS		CITY	STATE      ZIP
PARENT'S NAME – IF PATIENT IS A MINOR			
MOTHER		FATHER	
CHILD LIVES WITH – CIRCLE THE ONES THAT APPLY			
MOTHER	FATHER	STEP-MOTHER	STEP-FATHER      LEGAL GUARDIAN      OTHER:

### APPOINTMENT REMINDERS

PLEASE CHECK HOW YOU WOULD LIKE TO RECEIVE IT - We are changing the way that we provide reminder calls to each patient; so please read your options below and choose the one that you wish for.

<input type="checkbox"/> TEXT MESSAGE (REQUIRES CELL PHONE NUMBER & CARRIER)	<input type="checkbox"/> EMAIL (REQUIRES EMAIL ADDRESS)	<input type="checkbox"/> PHONE CALL (CALL WILL BE MADE TO THE NUMBER LISTED IN THE HOME PHONE LINE)
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### PHONE & EMAIL

HOME PHONE NUMBER	CELL PHONE NUMBER	WORK PHONE NUMBER & EXTENSION				
CELL PHONE CARRIER – PLEASE CIRCLE ONE – WE NEED TO KNOW THE CELL PHONE CARRIER IN-ORDER TO RECEIVE TEXT MESSAGE REMINDERS						
AT&T	VERIZON	SPRINT	T-MOBILE	METRO PCS	ALLTEL	BOOST MOBILE
NEXTEL	VIRGIN MOBILE	OTHER:				
EMAIL ADDRESS – WE NEED TO KNOW IN-ORDER TO RECEIVE EMAIL REMINDERS						

### APPOINTMENT REMINDER DISCLAIMER & CONSENT FORM

Kindelan McDanal & Associates is currently in the process of changing the way we offer Appointment Reminder calls to our patients. We will be utilizing a system that engages in Text Messaging, Email, and Automated Phone Calls for Appointment Reminders and other patient care related information. Patients may choose to change the method of how they receive their appointment reminder or other patient information at any time by speaking with a member of the office staff. Kindelan McDanal & Associates uses reasonable means to protect the security and confidentiality of texts and emails we send and/or receive, however, we cannot guarantee the security and confidentiality of the information sent through email and texting. Kindelan McDanal & Associates cannot be held liable for any breaches of confidentiality caused by the patient or any third party when using this system, as well as, any improper disclosure of confidential information that is not caused by intentional misconduct. This information is only used by Kindelan McDanal & Associates and is governed by the same HIPPA protection as all other patient information. **\*\* Please Note** – that if you need to cancel or reschedule an appointment after you receive your appointment reminder; you would need to call the office at 863-877-1855 and speak to the receptionist\*\*. I have read and understand the above information and agree to the terms set fourth.

\_\_\_\_\_  
Signature of Patient or Parent/Legal Guardian

\_\_\_\_\_  
Printed Name of Patient or Parent/Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

## PRIMARY INSURANCE (POLICY INFORMATION)

PRIMARY INSURANCE COMPANY NAME				CUSTOMER SERVICE PHONE NUMBER			
ID/MEMBER NUMBER			GROUP NUMBER			EFFECTIVE DATE	
PATIENT'S RELATIONSHIP TO INSURED – CIRCLE ONE			INSURED'S NAME – LAST NAME, FIRST NAME, MI			INSURED'S DATE OF BIRTH	
SELF      SPOUSE      CHILD      OTHER							
INSURED'S STREET ADDRESS				INSURED'S CITY		INSURED'S STATE	INSURED'S ZIP
INSURED'S GENDER – CIRCLE ONE		INSURED'S EMPLOYER					
FEMALE      MALE							

## SECONDARY INSURANCE (POLICY INFORMATION)

SECONDARY INSURANCE COMPANY NAME				CUSTOMER SERVICE PHONE NUMBER			
ID/MEMBER NUMBER			GROUP NUMBER			EFFECTIVE DATE	
PATIENT'S RELATIONSHIP TO INSURED – CIRCLE ONE			INSURED'S NAME – LAST NAME, FIRST NAME, MI			INSURED'S DATE OF BIRTH	
SELF      SPOUSE      CHILD      OTHER							
INSURED'S STREET ADDRESS				INSURED'S CITY		INSURED'S STATE	INSURED'S ZIP
INSURED'S GENDER – CIRCLE ONE		INSURED'S EMPLOYER					
FEMALE      MALE							

**MEDICARE AND INSURANCE: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you.** Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. **You agree to pay any portion of the charges not covered by insurance.**

\*\*\* If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company. Authorization received by your insurance company is NOT a guarantee of payment.\*\*\*

**Note that you are ultimately responsible for all fees incurred, excluding our negotiated provider discounts with insurance companies with whom we are a participating provider.**

**MEDICARE/INSURANCE AUTHORIZATION:** I authorize any holder of medical or other information about me to release information as needed to my insurance company, the Social Security Administration and Health Care Financing Administration, or its intermediaries, carriers, or billing agent of Kindelan McDanal & Associates, in order to process this claim. I permit a copy of this authorization to be used in place of the original. I request payment of the medical insurance benefits either to myself or to the party who accepts assignment.

I am responsible for any fees or services not covered by my Medicare or other insurance plan.

\_\_\_\_\_  
Signature of Patient or Parent/Legal Guardian

\_\_\_\_\_  
Printed Name of Patient or Parent/Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date