Hart Family Practice,PA

R Eric Hart, MD
Mandy Ferguson, FNP

Date_____

Patient Name _____
First *Middle* *Last*

Social Security #_____ Date of Birth_____ M or F (Please Circle)

Address _____
Street, City, State, and Zip Code

Home Phone_____ Cell Phone_____

Preferred Method of contact: (Please Circle) Cell Phone Home Phone Email

---

Marital Status_____ Spouse/Partner Name_____
M, S, D, W

Sexual Orientation_____

Emergency Contact
Name _____
Phone Number_____
Relationship to Patient_____

Email Address _____

Would you like to be a part of our Care360 patient portal? Yes or No (Please Circle)

Employer _____ Part Time Full Time (Please Circle)

Insurance Information
Group#_____ ID#_____

Policy Holder_____ Policy Holder DOB _____

Insurance Company Mailing Address _____
_____

Government Regulations require that we gather the following information for each of our patients:

Race: ____ Asian _____Native Hawaiian ____Other Pacific Islander ____White (Not Hispanic or Latino)

____Black/African American (Not Hispanic or Latino) ____American Indian/Alaska Native

____ Hispanic or Latino (All Races)

Language: _____ **Ethnicity:** ___ Hispanic or Latino _____ Not Hispanic or Latino

If you are completing this form for a minor please fill in information below:

Legal Guardian:_____ Date of Birth _____ Marital Status_____

SS# _____ Home #_____ Cell #_____ Work # _____

Address (if different):_____

Employer_____ Position_____Are calls allowed? Yes or No (Please Circle)

Father's Name_____ Date of Birth:_____ Marital Status_____

SS# _____ Home #_____ Cell #_____ Work # _____

Address (if different):_____

Employer_____ Position_____Are calls allowed? Yes or No (Please Circle)

Education (Highest Level Completed) _____ Religion (Optional) _____

Mother's Name_____ Date of Birth:_____ Marital Status_____

SS# _____ Home #_____ Cell #_____ Work # _____

Address (if different):_____

Employer_____ Position_____Are calls allowed? Yes or No (Please Circle)

Education (Highest Level Completed) _____ Religion (Optional) _____

Consent to Treatment

I am a new patient at Hart Family Practice. By signing this form, I consent to be treated by the providers of this practice.

I, _____, agree to let the providers and staff do tests, exams, or procedures to get this information. These may include:

- lab tests,
- screening tests (tests that can find an illness early, before a person shows signs of having a disease),
- diagnostic tests (tests that show when a person has a certain illness or health problem), and
- routine exams.

I understand that no promises have been made to me about the results of any treatment or services.

The doctor's office may need to contact me about my health or other matters. These calls may be automated phone calls (recordings) about my health, my appointments, or other healthcare services. These calls can be made to the phone number(s) I have provided, including my wireless number. I understand I may be charged for such calls by my wireless carrier and that these calls may be made by an automated dialing system.

__ I agree to receive these calls. Phone Number- _____.

__ I do NOT agree to receive these calls.

_____ _____
Signature of Patient or Responsible Party Date and Time

_____ _____
Witness Date and Time

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Hart Family Practice, PA

Patient Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of services, unless other arrangements have been made in advance with our practice manager. Necessary forms will be completed to help expedite insurance carrier payments. However, YOU ARE responsible for all fees, regardless of insurance coverage.

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including Medicare, private insurance and any other health/medical plan to issue payment check(s) directly to Hart Family Practice, PA for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

I hereby authorize Hart Family Practice, PA to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Hart Family Practice, PA on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this agreement is to be considered as valid as the original.

I will pay for all charges or make a co-pay and give an assignment of claims for my insurance carrier to make a direct payment to Hart Family Practice, PA.

_____ _____

Patient/Responsible Party Signature Date

Authorization for Release of Information – Compound Release

Name of Patient_____ Date of Birth _____

Hart Family Practice is authorized to release protected health information about the above-named patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other_____
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Revised Jan 2018

Hart
Family
Practice,PA

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:

  _____
- ❑ Other: _____

  _____

Prepared By _____

Signature _____

Date _____