**The Family Clinic**
**501 Hospital Rd., Starkville, MS**
**PATIENT INFORMATION**

Name______________________________ Date of Birth________ Sex________ Social Security #__________

Mailing Address____________________________________ City________________ State_____ Zip_______

Street Address_____________________________________ City________________ State_____ Zip_______

Home#:______________Work#________________Cell#________________Email__________________

Marital Status: Married __ Single__ Divorced__ Widowed__ Pharmacy______________________________

Emergency Contact______________________________ Phone________________ Relation__________

## EMPLOYMENT INFORMATION

Employed: Yes___ No___ Full time____ Part time_____ Retired_____

Employer____________________________________________ Phone__________________

Address______________________________ City__________________ State_____ Zip__________

Race______________ Ethnicity: Hispanic____ Not Hispanic___ Language__________

## GUARANTOR OR PERSON RESPONSIBLE FOR YOUR BILL

Name ______________________________Date of Birth__________ Social Security #______________

Phone: Home ______________Work______________ Cell______________ Relation to Patient__________

Mailing Address_____________________________City____________________ State_____ Zip_______

### Consent to Treatment, Payment, and Release of Health Information

The Family Clinic is committed to fair billing practices. We accept most insurance, however; there are many services that may not be covered by health insurance. Insurance policies are contracts between you and an insurance company. We frequently do not have access to your specific coverage and therefore must ask that payment in full be made at the time of service, unless prior arrangements are made. The Family Clinic will file primary and secondary insurance when required by contract. When not bound by contract, we will file only your primary insurance as a courtesy to you. We will make a reasonable effort to notify you in advance if we believe your services will not be covered. You are responsible for final charges not paid or not covered by insurance and/or any collection costs associated with your account. Any unpaid balances are due and payable immediately. Failure to make reasonable arrangements to pay your bill may result in referral of your account to a collection agency and/or termination of your care at this clinic. By signing below, you agree to abide by these policies.

I authorize/consent to treatment and to my medical provider/The Family Clinic releasing my protected health information consistent with our Notice of Privacy Practices including for Treatment, Payment, and Health Care Operations, and further consent to my Medical Provider/The Family Clinic to accept assignment and payment of benefits on my behalf. This authorization is intended for use with my current and future insurance coverage. I further acknowledge receiving Notice of Privacy Practices and clinic policy with opportunity to ask questions.

Signature__________________________________________________ Date______________
Patient/Guardian

Notice of Privacy policy declined________________________________________ Date______________
Patient/Guardian signature

Revised 10/2013