PATIENT INFORMATION SHEET

There are two pages to this form. Please complete both forms, if you are using health insurance.

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 OTHER	

PATIENT'S MAILING ADDRESS	CITY	STATE	ZIP

PARENT'S NAME – IF PATIENT IS A MINOR	
MOTHER	FATHER
STEP MOTHER	STEP 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 YOUR APPOINTMENT REMINDERS.

Reminder messages are sent by an automated system two days before your scheduled appointment. Please choose **one** delivery method. You may provide up to **two** different phone numbers or emails per reminder message.

☐ TEXT MESSAGE (REQUIRES CELL PHONE NUMBER)	☐ EMAIL (REQUIRES EMAIL ADDRESS)	☐ PHONE CALL (CALL WILL BE MADE TO THE NUMBER LISTED IN THE HOME PHONE LINE)

PHONE & EMAIL

HOME PHONE NUMBER	CELL PHONE NUMBER	SECONDARY CELL # & CONTACT NAME (OPTIONAL)

EMAIL ADDRESS	WORK PHONE NUMBER & EXTENSION

APPOINTMENT REMINDER DISCLAIMER & CONSENT FORM

Kindelan McDanal & Associates currently 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 will 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 forth.

______________________________ Signature of Patient or Parent/Legal Guardian

______________________________ Printed Name of Patient or Parent/Legal Guardian

______________________________ Relationship to Patient

______________________________ Date

CONTINUED

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 SELF SPOUSE CHILD OTHER	INSURED'S NAME – LAST NAME, FIRST NAME, MI		INSURED'S DATE OF BIRTH
INSURED'S STREET ADDRESS	INSURED'S CITY	INSURED'S STATE	INSURED'S ZIP
INSURED'S GENDER – CIRCLE ONE FEMALE MALE	INSURED'S EMPLOYER		

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 SELF SPOUSE CHILD OTHER	INSURED'S NAME – LAST NAME, FIRST NAME, MI		INSURED'S DATE OF BIRTH
INSURED'S STREET ADDRESS	INSURED'S CITY	INSURED'S STATE	INSURED'S ZIP
INSURED'S GENDER – CIRCLE ONE FEMALE MALE	INSURED'S EMPLOYER		

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 the claims. 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 Aetna, Blue Cross Blue Shield, Medicare or any other insurance plan.

______________________________ Signature of Patient or Parent/Legal Guardian

______________________________ Printed Name of Patient or Parent/Legal Guardian

______________________________ Relationship to Patient

______________________________ Date