Fredericksburg Christian Health Center
Providing Affordable Quality Health Care
To the Fredericksburg Community

PATIENT NAME _____ Today's Date: ___/___/___
Last Name First Name Middle Ini.

Date of Birth: ___/___/___ Age: _____ Marital Status: □ Single □ Married □ Widowed
□ Divorced □ Separated
Sex: □ Male □ Female Home Phone #: (____)_____-_____ Social Security #: ____-___-____
Race: _____ Cell Phone #: (____)_____-_____

Mailing Address: _____ City/County: _____ State: ____ Zip: _____

Physical Address: _____City/County: _____ State: ____ Zip: _____

Employer: _____ Work Phone #: (____)_____-_____ Occupation: _____

Employer's Address: _____

Email Address: _____

Patient's Spouse's Information
Wife/Husband's Name: _____Cell Phone #: (____)_____-_____SSN#: ____-___-____

Spouse's Employer Name: _____ Spouse's Work #: (__)_____-_____

Email Address: _____

IF YOU HAVE INSURANCE, PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD.
Type of Insurance: _____ Policy Holder Name: _____

Relation to Patient: _____ Policy Holder SSN #: ____-___-____ Policy Holder DOB: ___/___/___

IF PATIENT IS UNDER THE AGE OF 18 OR LIVING WITH PARENTS please fill out the next 2 areas

Father's Name: _____ SSN #: _____-____-_____ Date of Birth: ___/___/___

Mailing Address: _____ City/County: _____ State: ____ Zip: _____

Home #: (____)_____-_____Father's Employer: _____Father's Work #: (___)_____-_____

Mother's Name: _____ SSN #: _____-____-_____ Date of Birth: ___/___/___

Mailing Address: _____ City/County: _____ State: ____ Zip: _____

Home #: (____)_____-_____Mother's Employer: _____Mother's Work #: (____)_____-_____

EMERGENCY CONTACT NAME AND NUMBER: _____

Pharmacy Name and Number that you use for medications: _____

TO ALL PATIENTS:
We ask that all patients pay for their office visit at the time of service, unless you have prior arrangements made with our billing department or payment plan agreement.

TO OUR PATIENTS WITH INSURANCE COVERAGE:
If you have a co-pay with your insurance, you must pay it at each office visit. We will be happy to file all charges with your insurance once you have given us your complete insurance information. We will ask to run a copy of your insurance card. Insurance information must be provided within 30 days of the appointment or the patient will be made a self-pay. **However, if your insurance does not pay within 90 days, it is your responsibility to contact them in reference to payment.** If you do not want us to file with your insurance, please let us know. Please contact our billing department for any assistance you may need. You will be reimbursed for any overpayment made to us or your insurance will be reimbursed for overpayments made by your insurance company.

WORKMAN'S COMPENSATION PATIENTS:
If you were injured in the course of employment, we will file your compensation claim for you once we have verification from your employer, the insurance carrier, and claim number. We will still ask for your personal insurance information for future use if needed. **You will be responsible for any charges not pain within 90 days by your workman's compensation insurance.** If at any time we can help you with your compensation claim, please contact our billing department.

MEDICARE PATIENTS:
Medicare requires all Medicare patients to sign the following before we can file your claim.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Powell for any services furnished by that physician. I authorized any holder of medical information about me to release the Health Care Financing Administration and its agents, and to my insurance company, any information needed to determine these benefits or the benefits payable to related services.

_____ _____ _____
Medicare ID # Signature of Medicare Patient Date

ALL PATIENTS OR GUARANTOR PLEASE READ AND SIGN THE FOLLOWING:
I have read and understand all of the above. The information listed by me on the front is correct to the best of my knowledge. I am responsible for all bills not paid by insurance. I further agree in the event of nonpayment, to bear the cost of collection, and/or Court costs and reasonable legal fees should this be required. It is agreed that a photocopy serves at the original of this document. I have also read and understand all of the HIPPA rules designated on the Notice of Information Practices. If I do not want any of my PHI disclosed I agree to sign another form for that authorization.

_____ _____
Signature of patient Date

INSURANCE AND COMPENSTATION PATIENTS PLEASE READ AND SIGN THE FOLLOWING:
I authorize the release of medical information to my insurance carrier(s) and authorized insurance payment directly to Fredericksburg Christian Health Center.

_____ _____
Signature of patient Date

GUARANTOR FOR THIS PATIENT/ACCOUNT

_____ _____
Print Name Signature Date