PATIENT INFORMATION: (Please use full legal name, no nicknames)

*Last Name: ___________________________________ *First Name: _________________________________ Middle Initial: ___________

*Address: ____

City: ____ State: ___________________________ Zip: _____________________

Home Phone #: (________) ________-_______________ *Social Security #: ____

*Date of Birth: ___________________ Age: _________ *Sex: _______ Marital Status: ____________ Drivers Lic#: ______________

*Employer Name and Address: ____

____ Work Phone #: (________) ___________-_____________

E-mail Address: ____ Cell Phone #: (________) ___________-_____________

Pharmacy Name/Phone#____

Emergency Contact Name: ____ Emerg Phone #: (________) __________-_____________

Please tell us how you heard about us: _________________________________Referred by_____________________________________

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

Plan Name: ____ *Insured's Name: _____________________________________

Insured's Social Security #: ______________________________ *Insured's Date of Birth: ______________________________

*Policy / ID #: __________________________________ *Group #: _________________________ Eff Date: ___________________

Claims Address & Phone: ____

SECONDARY INSURANCE:

Plan Name: ____ *Insured's Name: _____________________________________

*Insured's Social Security #: ______________________________ *Insured's Date of Birth: ______________________________

*Policy / ID #: __________________________________ *Group #: _________________________ * Eff Date: ___________________

Claims Address & Phone: ____

DISCLOSURES & CONSENTS

Patient Name: ____ Date of Birth: ____________

First Name M.I. Last Name

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Integrated Healthcare of South Florida or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Integrated Healthcare of South Florida is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Integrated Healthcare of South Florida or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the Integrated Healthcare of South Florida Patient Information Privacy Policy. I hereby authorize Integrated Healthcare of South Florida or the physician individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize Integrated Healthcare of South Florida representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Integrated Healthcare of South Florida to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my Integrated Healthcare of South Florida physician or his or her designee.

PATIENT SIGNATURE: ______________________________________ DATE: ____________________

GUARANTOR SIGNATURE: ___________________________________ DATE: ____________________

(If different from patient)

GUARANTOR NAME (Please Print): ____