Patient Information Form

We use the information in this form to help provide you with the best care experience possible. All of the information you give us will be treated in accordance with all applicable confidentiality laws and practices and is intended solely for use by Intercede Health.

Patient Name: ______________________ Date of Birth: ______________________

Address: ______________________ City ______________ State __________ Zip Code __________

SS#: ______________________ Driver's License #: ______________________

What is the best number for us to call to reach you? ______________________

Who should we call in case of an emergency? ______________________ Relationship: ______________

Phone: ______________________

Is there someone else we can call if we can't reach you? *(List name & phone number)* ______________________

Are you... Married ☐ Single ☐ Widowed ☐ Divorced ☐

If you are married, what is your spouse's name? ______________________

Do you live with anyone other than a spouse? ______________ Who brings you to your doctor visits? ______________

Do you drive? ☐ Ride the bus? ☐ Need transportation? ☐

Pharmacy Name: ______________________ Phone: ______________________

Home Health Agency Name: ______________________ Phone: ______________________

Insurance Co. Name: ______________________ Insurance ID#: ______________________

Case Manager Phone: ______________________

WE WILL ASK TO MAKE A COPY OF YOUR INSURANCE CARD AND DRIVER'S LICENSE OR OTHER IDENTIFICATION.

Please read and initial each section below:

Insurance Coverage Waiver *if* coverage cannot be verified at this time
I understand that my eligibility for coverage by my insurance company cannot be confirmed at this time. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided. _____ *(Initial)*

Assignment of Benefits
I hereby assign to Intercede Health any insurance or other third-party benefits available for health care services provided to me. I understand that Intercede Health has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Intercede Health, I agree to forward to Intercede Health all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. _____ *(Initial)*

Consent to Treat
I give permission for Intercede Health TCC physicians and clinicians to perform medical examination, treatment and procedures that they deem necessary. I reserve the right to withdraw this permission. I understand that my medical information may be shared with other healthcare professionals involved in my care and to my insurance company and other healthcare facilities when necessary. _____ *(Initial)*

Receipt of Notice of Privacy Practices
I acknowledge that I have received a copy of Intercede Health's Notice of Privacy Practices. _____ *(Initial)*

Signature of Patient: ______________________ Date: ______________