DUKE CITY PRIMARY CARE

PATIENT INFORMATION & CONSENT FORM

Last Name: _____ First Name: _____MI_____MALE/FEMALE
Mailing Address: _____City: _____State: _____ Zip: _____
Physical Address: _____City: _____State: _____Zip: _____
Email Address: _____
Home #: _____ Work#: _____Cell #_____
SS#: _____/_____/_____ Birth Date: _____/____/_____ Driver's License #: _____
Employer: _____Employer Phone#: _____
Emergency Contact: _____ Relation: _____Phone#: _____

RACE:
___ Caucasian
___ African American
___ Native American
___ Hispanic/Latino
___ Other: _____

ETHNICITY
___ White
___ Hispanic/Latino
___ American Indian
___Other: _____

LANGUAGE
___ English
___ Spanish
___ Other_____

RESPONSIBLE PARTY

(This section must be completed if patient is under the age of 18)

Name: _____DOB: ____/____/____SS#: _____/____/_____
Phone Number: _____ Mailing Address: _____
City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

(It is important that this section is completed)

Primary Insurance: _____ Subscriber Name: _____
Subscriber SS#: _____/_____/_____
Insurance Address: _____ City: _____State: _____ Zip: _____
Insurance Phone: _____ Policy/ID#: _____ Group#: _____
Secondary Insurance: _____ Subscriber Name: _____
Subscriber SS#: _____/_____/_____
Insurance Address: _____ City: _____State: _____ Zip: _____
Insurance Phone: _____ Policy/ID#: _____ Group#: _____

AUTHORIZATION & AGREEMENT BY PATIENT

Please READ & SIGN the following Authorization and Assignment

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance payment. It is customary to pay for services when rendered unless arrangements are made in advance.

I hereby authorize Duke City Primary Care to furnish information to insurance carriers concerning my illnesses and treatments and I hereby assign to Duke City Primary Care, Inc all payments for medical services rendered to myself or dependents. I understand that I am fully responsible for any amounts not covered by my insurance.

Signature: _____ Date: _____

Relationship to Patient: _____

No Show Penalty Fee

If you do not call and cancel your appointment 24 hours prior to the scheduled appointment and elect not to attend your appointment, you will be charged a $25.00 fee.

If you are late for your appointment, your appointment may be cancelled and you will be rescheduled. This may result in a $25.00 fee.

_____ _____

Patient/Guardian Signature Date

AUTHORIZATION OF ASSIGNMENT OF BENEFITS
RELEASE OF INFORMATION AND CONSENT FOR TREATEMENT

I hereby authorize payment directly to Duke City Primary Care for services rendered and supplies provided by New Mexico Medical. I understand that this assignment is for all benefits otherwise payable to me, but not to exceed my indebtedness to said Clinic. I authorize Duke City Primary Care, Inc to release any information acquired in the course of treatment or examination. I understand that am financially responsible to Duke City Primary Care, Inc for charges not covered by this assignment. I authorize the release of any and all medical information necessary to process these claims and I request payment of any benefits due to me or for my benefits to be made directly to Duke City Primary Care.

I hereby authorize and consent to be treated by Duke City Primary Care, Inc physicians and staff. The undersigned consents to any X-ray, examination, laboratory, procedures, anesthesia, minor surgical procedures or any medical services rendered under the general or specific instruction of the Duke City Primary Care physicians. The undersigned recognizes that some persons furnishing professional medical services, including but not limited to radiology and pathology, may independent contractors and not employees or agents of the Clinic.

AGE OF CONSENT – WHERE MINORS ARE INVOLVED, THE FOLLOWING SHALL PREVAIL:

1) The consent of parent or legal guardian if patient is unmarried and has not yet attained the age of (18)

2) If a patient under the age of (18) years of age is married, or has been married and such marriage has been dissolved by dissolution or annulment, then the consent of a parent or guardian is not required.

The undersigned hereby acknowledges that he or she has read and fully understands the foregoing, and has voluntary executed this document. The undersigned further acknowledges that he or she is the patient, or is duly authorized by and on the behalf of the patient to execute this document, and accepts its terms personally and upon the patient's behalf.

The release of information set forth herein above is valid, and the assignment of benefits and financial agreement is valid and binding until final settlements of the account is received

SIGNATURE: _____ DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ acknowledge that I have received a copy of Duke City Primary Care **"NOTICE OF PRIVACY PRACTICES"**. This notice describes how Duke City Primary Care may use and disclose my protected health information, and rights that I have regarding my protected health information. I have also been offered a copy of Duke City Primary Care **"Notice Of Advanced Directives"** and I have accepted or declined to fill out the Advanced Directives form and have them included in my chart.

_____ _____

Signature of Patient or Patients Representative **Date**

_____

Relationship to Patient