HealthReach

Please present your Insurance Cards and Photo I.D. to reception staff – Thank You.

PATIENT INFO:
Date of Birth: _____
Name *(First MI Last)*: _____
Sex: □ Male □ Female
Address: _____ APT: _____
City, State, Zip: _____
Email Address:_____
Home Phone: _____
Cell Phone: _____
Leave Message: □ Yes □ No
Primary Care Doctor:_____

Preferred Language: □ English □ Spanish □Other_____
Race: □ American Indian/Alaskan Native
□ Asian
□ Black/African American
□ Native Hawaiian/Pacific Islander
□ White/Caucasian
Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino
REFERRED BY: □ Billboard □ Business □ Direct Mail
□ Employer □ Existing Pt □ Friend/Family □ Internet
□ Insurance □ Radio □ Newspaper □ Physician □ TV
□ Social Media □ Website □ Self
EMERGENCY CONTACT:
Name: _____
Address: □ Same as Patient
_____ Apt: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Relationship: _____
GUARANTOR INFO: ***(I.E. Responsible Party for Minors)***
Date of Birth: _____
Name: *(First MI Last)*_____
Address: □Same as Patient
_____ Apt: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
PATIENT EMPLOYMENT:

Employer: _____

PRIMARY INSURANCE: _____
Policy ID: #_____
Group ID: #_____
Relation to Policy Holder:
□Self □Spouse □Dependent □Other _____
Name *(First MI Last)*: _____
Date of Birth: _____
Address: □Same as Patient
_____ Apt: _____
City, State, Zip: _____
Employer: _____
SECONDARY INSURANCE: _____
Policy ID: #_____
Group ID: #_____
Relation to Policy Holder:
□ Self □ Spouse □Dependent □Other _____
Name *(First MI Last)*: _____
Date of Birth: _____
Address: □Same as Patient
_____ Apt: _____
City, State, Zip: _____
Employer: _____

Independent Contractor Status. *I understand that my treating physicians, physician assistants, and other healthcare providers who provide care and treatment to me at HealthReach may be independent contractors and not employees of HealthReach. I further understand that this means that said providers are not agents of HealthReach and only the provider is responsible for the care and treatment provided. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.* **WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE BEGINNING OF EACH VISIT.**

I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private and other agency reimbursements to HealthReach. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

YOUR BILL WILL BE AUDITED: *Additional charges may be applied. Medicare and private insurance companies may deny a charge as an "unnecessary" service. I agree to be personally responsible for payment for services performed.*

Signature:_____Date:_____