Welcome to Sound Family Health

Patient Information- Please Print

Date________________ Soc Sec#__________________ Birth Date___/___/____ Sex [ ] M [ ] F

Last Name______________________ First Name__________________________ MI_________

Race (please circle one) Caucasian / Native American / Hispanic / African American / Asian / Other_________

Language __________Marital Status_______Employer________________

Mailing Address ____
Street Number or P.O. Box City State Zip

Primary Phone #_____________Alternate Phone #_____________________Email_______________

Spouse, Parent or Guardian Information- Please Print

Last Name______________________ First Name ________________________ Sex [ ] M [ ] F

Birthdate___/___/____ Soc Sec#____________ Relationship to Patient __________Phone#__________

Primary Insurance Carrier-Please Print

Primary Ins. Carrier_______________ Subscriber ID #__________________Group#____________

Subscriber's Name ____________________Birthdate___/___/___Relationship to Patient_________

Secondary Insurance Carrier-Please Print

Secondary Ins. Carrier_____________ Subscriber ID #__________________Group#____________

Subscriber's Name____________________ Birthdate___/___/___Relationship to Patient_________

Financial Policy and Patient Signature of File

As a courtesy to all our patients, Sound Family Health will file a claim with your insurance company. However, this is not a guarantee of payment, therefore it is important for you to be aware of your insurance coverage, benefits and limitations. Ultimately, financial responsibility for services rendered rests with the patient or his/her guardian regardless of the nature or extent of the balance remaining after receipt of any insurance payment.

I have read, understand and agree to the financial policy as state above. I hereby authorize payment of medical benefits to Sound Family Health for any services furnished to me by a provider of Sound Family Health. I authorize the physician and clinic to release any information to process insurance claims. This authorization is in effect indefinitely.

Patient/Guardian Signature______________________________________**Date**___/___/____

Patient/Guardian Printed Signature________________________________ **Date**___/___/____

Private Pay Patients

I understand that payment in full is expected at the time of service. If I am unable to pay in full, I agree to contact the billing office to discuss payment options available, prior to my appointment.

Patient/Guardian Signature______________________________________**Date**___/___/____

Medicare Recipients Only-Medicare Beneficiary Lifetime Authorization

I request that payment of authorized MEDICARE benefits be made to me or on my behalf to Sound Family Health for any services furnished to me by the providers. I authorize Sound Family Health to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

____

Signature of Medicare Patient or Legally authorized individual Date

Sound Family Health
Privacy and HIPAA Form

Last Name____________________First Name_____________________Birthdate___/___/__

Please CHECK all that apply:

Does the staff of Sound Family Health have your permission to leave messages in the effort to contact you regarding medical and/or financial information on your messaging system?

Primary Phone# (__ __ __) __ __ __-__ __ __ __ [ ] YES [ ] NO **

Alternate Phone# (__ __ __) __ __ __-__ __ __ __ [ ] YES [ ] NO **

Work Phone # (__ __ __) __ __ __-__ __ __ __ [ ] YES [ ] NO **

Email address__________________________________ [ ] YES [ ] NO *

***Please be aware Emails are sent via Secure messaging only and could take up to 48hours for a response; do NOT send urgent/important emails. Please contact the office directly. **If "NO" is checked; ONLY the date, time and location of an appointment will be left on your messaging system.**

I give authorization to the staff of Sound Family Health to discuss my medical and/or financial information with the following people as needed or as it pertains directly to my care. This form may only be changed in writing; the amended form is available at the front desk.

1.____
Name Relationship Primary Phone Number

2.____
Name Relationship Primary Phone Number

3.____
Name Relationship Primary Phone Number

Treatment Authorization of Minors

I, the undersigned parent or guardian of ____________________________(patient's full name), grant permission and authorize medical care and treatment for the above mentioned minor, if minor should present to Sound Family Health without a parent or guardian.

Parent/Guardian Signature____Date___/___/___

Parent/Guardian Printed Signature__________________________________Date___/___/___

Sound Family Health
Notice of Privacy Practices

September 2013

A federal law commonly known as HIPAA requires that we take additional steps to keep you informed about how we may use information that is gathered in order to provide health care services to you. As part of this process, we are required to provide you with the attached Notice of Privacy Practices and to request that you sign the attached written acknowledgement that you received a copy of the Notice. The Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information we maintain about you and a brief description of how you may exercise these rights.

This form will be retained in your medical record.

Acknowledgement of Receipt of
Notice of Privacy Practices

By my signature below I, ______________________________, acknowledge that I received a copy of the Notice of Privacy Practices for Sound Family Health.

____   ____________________

Signature of patient (or personal representative)   Date

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ________________________________

Relationship to Patient: ________________________________

BELOW FOR OFFICE USE ONLY

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ____ Individual refused to sign
- ____ Communication barriers prohibited obtaining the acknowledgement
- ____ An emergency situation prevented us from obtaining acknowledgement
- ____ Other – Please specify ______________________________

Employee Name ______________________________ Date ____________________