Patient Account Number ____________

Family Health Care of Newtown
Newtown, Connecticut 06470

Date ____________

PATIENT INFORMATION

PATIENT'S NAME
(Last, First, Middle Initial)

RESPONSIBLE PARTY
(IF A MINOR)

PATIENT'S ADDRESS

CITY STATE ZIP

Home Phone ( ) -
Cell Phone ( ) -
DATE OF BIRTH ___/___/___ MO DAY YR

AGE SS # SEX MARITAL STATUS

RACE
- ☐ Alaskan Native
- ☐ American Indian
- ☐ Asian
- ☐ Black
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ White
- ☐ Other____________

ETHNICITY
- ☐ Hispanic/ Latino
- ☐ **NOT** Hispanic/ Latino

INSURANCE INFORMATION

PRIMARY INSURANCE

SECONDARY INSURANCE

PATIENT'S EMPLOYER / SCHOOL INFORMATION

NAME ____________________________

ADDRESS ____________________________

CITY ______________ STATE ____ Phone ( )__________ EXT_____

POLICYHOLDER OR RESPONSIBLE PARTY INFORMATION

PRIMARY POLICYHOLDER'S NAME (Last, First, Middle Initial) DATE OF BIRTH ___/___/___ MO DAY YR

EMPLOYER'S NAME OR SCHOOL NAME PHONE NUMBER ( ) -

EMPLOYER'S ADDRESS

CITY STATE ZIP

SOCIAL SECURITY NUMBER RELATIONSHIP TO PATIENT •Spouse •Parent •Other ____________

EMPLOYER PLAN COVERAGE • Yes • No
IF CHAMPUS: •Active •Retired • Deceased
Branch of Service: ______________

SECONDARY POLICYHOLDER'S NAME (Last, First, Middle Initial) DATE OF BIRTH ___/___/___ MO DAY YR

EMPLOYER'S NAME OR SCHOOL NAME

EMPLOYER'S ADDRESS

CITY STATE ZIP

SOCIAL SECURITY NUMBER RELATIONSHIP TO PATIENT •Spouse •Parent •Other ____________

EMPLOYER PLAN COVERAGE • Yes • No
IF CHAMPUS: •Active •Retired • Deceased
Branch of Service: ______________

Please be sure to fill out both sides of this form and sign on the back. Thank you.

IN CASE OF AN EMERGENCY	NAME ______________________	Phone Home ( ) __________
-WHO SHOULD WE CONTACT?- (Please list someone not living at your residence)	ADDRESS ______________________	Phone Bus. ( ) __________
	CITY ____________ STATE ____	RELATIONSHIP __________

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. Some companies pay fixed allowances on certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by you or your insurance.

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF DIRECTLY TO **THE FAMILY HEALTH CARE CENTER, LLC.**

I certify that the above information is true. I authorize the release of all medical records to my primary care physican, other treating physicans and to my insurance company. If applicable, I understand that payment of charges incurred is due at the time of service unless other definite arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

SIGNATURE ________________________________ **DATE** ______________

PHYSICAN NOTICE TO PATIENT ABOUT MEDICARE

Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862 (a) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service.

____

MEDICARE RECIPIENTS SIGNATURE DATE

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of **FAMILY HEALTH CARE CENTER, LLC. NOTICE OF PRIVACY POLICIES,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the content of the notice, and I request the following restiction(s) concerning the use of my personal medical information:

SIGNED ________________________________ **DATE** ______________

If not signed by patient, please indicate relationship to patient (e.g., spouse)

RELATIONSHIP ________________________ **WITNESSED BY** ______________

FOR INTERNAL USE ONLY: (DO NOT WRITE BELOW THIS LINE)

If patient or patient's representative refuses to sign the acknowledgment of receipt of notice, please document the date and time the notice was presented to the patient and sign below.

PRESENTED ON: ________________________ **BY** ________________________

Date and Time / Name and Title