PATIENT INFORMATION

Name: _____ Sex: __ Female __ Male
Date of Birth: _____ Social Security # _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____@_____
Home Phone: _____ Mobile Phone: _____Consent to Text: Y N
Employer: _____ Work Phone: _____
Contact Preference (please cirlcle): Home Phone Mobile Phone Email Patient Portal
Race: __ Asian __ Black or Africian American __ White __ Other Race: _____
Martial Status: ____ Single _____ Married _____ Seperated _____Widowed _____ Partner

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____
Home Phone: _____ Mobile Phone: _____

PRIMARY INSURANCE

Insurance Company Name:_____
ID Number:_____ Group Number: _____
Policy holder information (if different from patient):
Name: _____ Date of Birth: _____

SECONDARY INSURANCE

Insurance Company Name:_____
ID Number:_____ Group Number: _____
Policy holder information (if different from patient):
Name: _____ Date of Birth: _____

Patient Authorizations and Acknlowdgements

1. I have been provided with a copy of the Clayton Family Medicine Notices of Privacy Practices.
2.ASSIGNMENT AND RELEASE OF BENEFITS: By signing below I hereby assign my insurance benefits to be paid directly to Clayton Family Medicine. I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan. I authorize the physician to release any medical information required to process this claim. I authorize my provider's office to contact me by telephone, text and email to remind me of my appointments.
3. If I am a Primary Care patient and qualify for Chronic Care Management through my insurance, I will be enrolled in the program here at Clayton Family Medicine.
4. A $20 fee for no shows may apply.

Consent to Treatment

The signature below serves as consent for Clayton Family Medicine care providers and staff to provide medical services and treatments to the above mentioned patient. Also, signing below provides consent for protected health information to be released for the purposes of treatment, referrals, and insurance reimbursements for services performed.

_____ _____ _____

Patient or Guardian Signature Relationship to patient Date

Authorization of Disclosure

The Clayton Family Medicine knows that privacy regulations have an impact on our customer services to you, especially when it comes to discussing information about you with family, friends, and others that you designate who are involved in your care..

What are some examples of when this might be useful?

- If an elderly parent wants an adult child to help with understanding medical treatments and instructions
- If a friend is helping an elderly patient with health issues
- If a college student would like for their information to be shared with a parent

We have established a process that allows you to inform us who we may talk with about your medical care. By completing this form, you are indicating that our group of providers and staff members is able to discuss your information with those individuals that you have listed below. Check the appropriate boxes to indicate what information we may discuss with each individual:

____ None – do not discuss my information with anyone other than myself

Name & Phone Number	Relationship to Patient: (Parent, Spouse, Sibling, Friend, etc.)	Billing Information	Medical/Health Information

Signing below provides Clayton Family Medicine consent to discuss my information with those individuals that I have indicated above. I understand that I can change this authorization, but that all changes must be submitted in writing.

_____ _____ _____

Patient or Guardian Signature Relation to Patient Date