Infinity Family Clinic

ALWAYS BY YOUR SIDE

Patient General Information (please print)

Name:_____DOB:_____Sex: M / F

SSN:_____Status: single/ married/ divorced/ widowed

Primary address:_____

City:_____State:_____Zip:_____

home #:_____Cell:_____work:_____

E-mail:_____

Emergency contact:

Name:_____Phone #:_____

Relationship:_____

Sharing of Medical Information:

I give the physician and office staff of Infinity Family Clinic permission to discuss my medical condition with the following individuals:

Name:_____Relationship:_____

Name:_____Relationship:_____

Pharmacy:

Name:_____Phone #:_____

Address:_____

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Patient Authorization for MEDICARE PATIENTS:

I authorize he physician and/or staff of Infinity Family Clinic to release to the social security administration, Health Care Financing Administration or its intermediaries or carriers any information needed for this or any Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits wither to myself or to the party who may cause Medicare payment information to cross over automatically to my supplement insurer. I understand that I am financially responsible for any services deemed non-covered by Medicare:

Patient Signature:_____Date:_____

Patient Authorization for PPO and HMO patients

I authorize the physician and/or staff of Infinity Family Clinic to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my insurance company to pay directly to Infinity Family Clinic the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my insurance company.

Patient Signature:_____Date:_____

Patient Authorization for ALL PATIENTS:

IFC is committed to providing quality care and pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility as our patient. It is your responsibility to notify us of any changes to your information, such as changes in address, phone number and/or insurance.

*Payment is due at time of service unless arrangement has been made with management.

*It is your responsibility to understand your insurance benefits.

*There is a $ 35 fee for any returned checks.

I understand that I am financially responsible for services in the offices non-covered by insurance. I also understand the financial policy of Infinity Family Clinic.

Patient Signature:_____Date:_____

ACKNOWLEGEMENT OF RECEIPT OF PRIVACY PRACTICES:

Notice to patients: We are required to provide you with a copy of our Notice of Privacy Practices which states how we may use and/or disclose your health information. Please sign to acknowledge receipt of notice. I acknowledge that I received a copy of the Infinity Family Clinic Notice of Privacy Practices.

Patient Signature:_____Date:_____

PATIENT CONSENT TO TREAT:

I hereby give my consent to Infinity Family Clinic and authorize provided medical treatment. I understand that Infinity Family Clinic will explain my condition(s),

foreseeable risks, and methods of treatment for my condition before treatment that is thought necessary if, in an emergency, a condition is discovered that was not known previously.

I have carefully read, and I fully understand this Patient Consent to Treat and have had the opportunity to discuss my condition and the above procedure(s) with the care provider. All my questions have been adequately answered.

Patient Signature:_____Date:_____

CANCELLATION AND NO-SHOW POLICY:

Our policy is as follows: Non-cancellation/ No shows within 24 hours notification: $30.00 fee for patients who do not show up for their appointment without a call to cancel and office appointment will be considered as a NO SHOW. Patients who NO SHOW three (3) or more times in a 12-month period, may be dismissed from the practice thus they will be denied any future appointments. The Cancellation and no-show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived with management approval. Our practice believes that good physician/patient relationship is based upon understanding and good communication.

Patient Signature of NO-SHOW acknowledgment:_____