the SUMMIT

Patient Name: _____ ____ _____ SS#:_____
(First) (MI) (Last)

Date of Birth: _____Age: _____ Sex: _____ Marital Status: ❑Single ❑Married ❑Widowed ❑Divorced

Home Address: _____ P.O. Box: _____

City.:_____ State:_____ Zip Code: _____

Home Phone:( ) _____ Cell Phone:( ) _____ E-mail address: _____

Employer: _____ Work Phone: ( ) _____ Spouse Name: _____

Spouse Employer:_____ Work Phone: ( ) _____ Spouse DOB: _____

Emergency Contact: _____ Relationship: _____ Phone: ( ) _____

Referring Physician: _____ Primary Physician: _____

Pharmacy & Location: _____ Phone: ( ) _____

I give permission for Summit Healthcare to contact the patient's pharmacy for a list of medications. ❑ Yes ❑ No

Race: ❑ Hispanic ❑ Asian ❑ Caucasian ❑ Black/African American ❑ American Indian or Alaska Native ❑ Other: _____

Ethnicity (Nationality-cultural background): ❑ Hispanic/Latino ❑ Non-Hispanic/Latino ❑ Other

Primary Language: _____

-Complete if Student or Minor-

Father Information

Name: _____

Address: _____

City, St., Zip: _____

Home Phone: ( ) _____

Work Phone: ( ) _____

Employer: _____

SS#: _____ DOB: _____

Mother Information

Name: _____

Address: _____

City, St., Zip: _____

Home Phone: ( ) _____

Work Phone: ( ) _____

Employer: _____

SS#: _____ DOB: _____

-Person Responsible for Payment of Account-

Name: _____ Relationship: _____

Address: _____ Home Phone: ( )_____

City, St., Zip: _____ Other Phone: ( )_____

-Insurance Information-

Please Present Card(s) for Copying

Primary Insurance: _____ Policy #: _____ Group #: _____

Ins. Address: _____ Ins. Phone: _____

Card Holder's Name: _____DOB: _____ SS#: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Ins. Address: _____ Ins. Phone: _____

Card Holder's Name: _____ DOB: _____ SS#: _____

I hereby give my consent to Summit Healthcare and its business associates to use and disclose my protected health information for the purpose of treatment, payment, and health care operations as noted in the Notice of Privacy Policies provided to me by the practice. I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full. If Summit Healthcare chooses to accept assignment of my health insurance benefits, I hereby assign all payments to which I am entitled. I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I take full responsibility for all costs incurred by my failure to pay for services rendered.

Signature of Patient or Patient's Representative: _____ Date: _____

Date of Birth: _____ Patient Chart: _____

Patient Name: _____ _____ _____ _____
(First) (M) (Last)

-Acknowledgement of Receipt of Privacy Notice-

I acknowledge I have received a copy of The Woman's Place's Notice of Privacy Practices effective April 2003.

-Authorization for Medical Care-

I hereby authorize Summit Healthcare to provide me medical treatment for any and all conditions they deem appropriate. I understand the physician or other provider will review the recommendations for testing and/or treatment they deem appropriate for my medical needs based on their professional judgment.

-Referral Waiver-

I acknowledge in the course of my treatment, Summit Healthcare, may refer me to other health care facilities and/or providers for diagnostic tests, treatment, or consultation. Summit Healthcare will notify me when such a referral occurs. Summit Healthcare assumes no responsibility for knowing if the facility or provider I am referred to is contracted with my insurance plan. Should Summit Healthcare make such a referral, it is my responsibility to verify my insurance coverage, eligibility, pre-certification (if applicable), and whether or not the facility or provider I am referred to contracts with my insurance company. Summit Healthcare is not responsible should my insurance process claims at the non-contracting level for the referred service(s).

-Communication Preferences-

By signing below**, *I give permission to the person(s) listed to receive LIMITED information about my care*.** I understand my healthcare provider will utilize their professional judgment to ensure that information is shared with family/friends in order to assist with my continuing care. **Any request for information not directly relevant to participation in care and any requests for copies of medical records will require a signed HIPAA compliant authorization.** This permission will be considered valid for one year unless otherwise revoked in writing.

Note: If you want to give an individual more access to your health information than offered below, you must complete a valid authorization form stating in detail the nature of the information you want released (see receptionist).

Please indicate your preferences below:

1. ☐ Do **NOT** share ANY information with anyone.
2. Please identify below individual(s) you would like us to share information with and mark the appropriate boxes regarding the type(s) of information we can share with each respective individual(s).

Name: _____ **Relationship:** _____

☐ Appointment Dates and Times. ☐ Relevant Test Results & Treatment Recommendations ☐ Billing Information

Name: _____ **Relationship:** _____

☐ Appointment Dates and Times. ☐ Relevant Test Results & Treatment Recommendations ☐ Billing Information

Physicians/Providers:

☐ You may also share information, including medical records, with the following physicans/providers who participate in my care:

Name: _____ **Name:** _____

_____ _____ _____
Signature of Patient or Personal Representative **Printed Name** **Date**

If Personal Representative, Relationship to Patient: _____
Date of Service: _____