

HAMPTON FAMILY PRACTICE PATIENT INFORMATION FORM

Please complete this form in the entirety, including both front and back pages. Thank you

Hampton Family Practice requires this information form to be completed annually or earlier to accompany a change in your information.

PATIENT	First Name			Middle Initial	Last Name	Preferred Name	
	Date of Birth	Age	Gender: M F	Marital Status: M S D W		Social Security Number	
	Race (optional) <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Other			Ethnicity (optional) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino Primary Language: _____			
	Patient Mailing Address		Apt #	City		State	Zip Code

CONTACT INFO	Home Phone ()		Work Phone () Employer Name:		Cell Phone ()	
	Please circle the preferred telephone number for communications (circle): Home Work Cell <i>_____ initial: I understand that Hampton Family Practice may use automated appointment reminder software in the form of text messaging when a cell phone is capable of receiving that format. Otherwise, a phone call reminder will be used. If you wish to opt-out of this feature, please notify the front desk staff.</i>					
	E-mail Address (please print clearly): _____ <i>By providing an e-mail address, I understand that Hampton Family Practice may send me practice announcements, newsletters, services, etc. Protected Health information will only be transmitted using the secure patient portal.</i>					

RESPONSIBLE PARTY (skip if same as patient)	First Name			Middle Initial	Last Name	Nickname	
	Date of Birth	Age	Gender: M F	Marital Status: M S D W		Social Security Number	
	Mailing Address		Apt #	City		State	Zip Code

Insurance Information - Please present your insurance card so we may make a copy of it for your record.

PRIMARY INSURANCE	Insurance Company Name		Group Number		Insurance ID Number	
	Subscriber Name	Date of Birth	Subscriber Social Security Number		Subscriber Relationship to Patient	
SECONDARY INSURANCE	Insurance Company Name		Group Number		Insurance ID Number	
	Subscriber Name	Date of Birth	Subscriber Social Security Number		Subscriber Relationship to Patient	

Financial agreement and insurance assignment: I hereby authorize treatment by any Hampton Family Practice provider and/or affiliated medical staff member(s). I further authorize release of any/all medical charge information as is necessary for third party reimbursement from any insurance carrier, Tricare or Medicare. I authorize direct payment from the provided insurance to this practice. I accept responsibility for the payment of all charges incurred including co-payment, coinsurance, deductible, non-covered services with your specific plan, missed appointments, attorney's fees and any other collection related costs if necessary. If I have insurance that requires a specific primary care provider for payment, I understand that I may be responsible for charges incurred if the provider assigned is not at Hampton Family Practice. I understand it is my responsibility to notify Hampton Family Practice of any changes in health insurance coverage.

For Medicare Beneficiaries Only: I request that payment of authorized Medicare benefits be made on my behalf to Hampton Family Practice for any services furnished me by Hampton Family Practice. I authorize any holder of medical information about me to release to the Center for Medicare (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the CMS-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, Hampton Family Practice agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered or excluded services.

Signature of Patient/Responsible Party

Relationship to Patient

Date

Patient Name: _____ Date of Birth: _____

Pharmacy	Name	Phone number (incl area code)
	Location	

Additional Information

IMMEDIATE FAMILY MEMBERS SEEN HERE

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____

EMERGENCY CONTACT	First Name	Middle Initial	Last Name	Relationship to Patient
	Street Address	City	St	Zip Code

RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Hampton Family Practice to DISCUSS my health information with the following individuals:
(A medical records release form will still be required to release actual copies of your medical records.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please check one of the following statements: I authorize: any/all information requested by the above parties OR

the following specific information: _____

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

HIPAA Acknowledgment:

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. By providing your signature, you acknowledge that you have reviewed our notice before signing this consent. To obtain a personal copy of our Notice of Privacy Practices, notify the front desk staff.

Signature of Patient/Responsible Party

Relationship to Patient

Date