Patient Name:_____ Patient Birthdate: _____/_____/_____
(last) (first) (middle initial)

Patient Age:_____ Patient Social Security #:_____/_____/_____ Marital Status:_____

Ethnicity: (circle) American Indian Black Caucasian Hispanic Non Hispanic Other

Race: (circle) American Indian Asian Black or African American Caucasian/White Hispanic Non Hispanic Other

Mailing Address or PO Box:_____

City:_____State:_____Zip:_____ E-mail:_____

Home Phone:(____)_____-_____ Cell:(____)_____-_____ Work Phone:(_____)_____-_____

Employment Status: □ Full-Time □ Part-Time □ Unemployed □ Student □ Retired

Employer:_____

Emergency Contacts

Name:_____ Relationship:_____

Home Phone:(____)_____-_____ Cell Phone:(____)_____-_____ Work Phone:(_____)_____-_____

Person responsible for any balance on this account-(only if the patient is a minor)

Name:_____ Social Security#:_____/____/_____

Relationship:_____ Birthdate: _____/_____/_____

Street Address:_____ City:_____ State:____ Zip:_____

Home Phone:(____)_____-_____ Cell Phone:(____)_____-_____ Work Phone:(_____)_____-_____

Employer:_____

Employment Status: □ Full-Time □ Part-Time □ Retired □ Unemployed

Primary Insurance Information ****Please present all insurance cards to the Receptionist****

Insurance Company:_____

Name of Policy Holder/Insured:_____ Insured Date of Birth:____/___/_____

Relationship to Patient:_____ Employment Status: □ Full-Time □ Part-Time □ Retired □ Unemployed

Second Insurance (if applicable)

Insurance Company:_____

Name of Policy Holder/Insured:_____ Insured Date of Birth:____/___/_____

Relationship to Patient:_____ Employment Status: □ Full-Time □ Part-Time □ Retired □ Unemployed

~~Please Read Authorizations and Polices on back~~

I have read and agree to the authorizations and policies of IMC-Eastern Shore Family Practice as documented on this form.

Patient or Responsible Party Signature:_____ Date:_____

FINANCIAL RESPONSIBILITY – I understand that I am responsible for all charges not paid by my insurance plan except those amounts that IMC-ESFP is contractually obligated to write off. I understand that I am responsible for all non-covered services and by signing this form I acknowledge I have been made aware of my obligation prior to receiving such services. I understand that if I do not pay for the charges for which I am responsible for, IMC-ESFP may turn my account over to a collection agency. I understand that should my account be turned over to a collection agency, I may be charged a collection fee, not to exceed 25% of my account, and I accept these fees charged by IMC-ESFP as a legal and lawful debt and agree to pay such fee if charged. Please remember that your insurance policy is a contract between you and your insurance carrier. Patients without insurance are expected to pay at the time the service is rendered.

Well (Preventive) vs. Sick Visit-A well visit is an appointment in which the patient has no complaints/concerns or medical diagnosis. This is considered a routine preventive visit. A sick visit is when the patient has complaints/concerns, a pre-existing diagnosis, or the physician discovers a medical concern that needs to be addressed that day. If your appointment is for a well exam and there is also a concern addressed that day, you may be charged an office visit in addition to your wellness visit. In this case, your regular co-pay and/or deductible will apply in addition to your wellness co-pay and/or deductible (if applicable).

Co-pays are due at the time of your service**.**

No Show Appointments and Late Cancelations – I understand when I make an appointment time is reserved for me that cannot be scheduled for someone else. Recognizing this I will, exempting unforeseen emergencies, notify IMC-ESFP no later than the business day before my appointment should I not be able to keep my appointment. If I do not, I understand IMC-ESFP has the right to charge me a no show fee and I acknowledge such a charge would be a legal and lawful debt and agree to pay such fee if charged.

Returned Check (NSF) - If you present a check that is returned to Women's Health Alliance for non-sufficient funds, a $30.00 fee will be charged to your account.

Laboratory Services - Please remember that specimens sent to labs outside the IMC-ESFP laboratory are billed separately from lab performed in our office. You will be billed separately from the laboratory.

Minors – I understand that I am responsible for this child's account and any agreement otherwise by means of a court decree or other valid agreement is between me and another party.

Assignment of Benefits –I request that payment of authorized Medicare and/or Medicaid benefits to me or on my behalf for services in or by IMC-ESFP shall be made to IMC-ESFP, and I specifically assign such benefits to the IMC-ESFP. If applicable, I hereby assign and authorize payment directly to IMC-ESFP all medical benefits under any insurance or third party plan payable to me or which I am otherwise entitled.

Authorization to Treat – I voluntarily consent to medical treatment and diagnostic procedures provided by IMC-ESFP. I/we are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the results of treatments and/or examinations.

Release of Information-I authorize any holder of medical information about me to release to Medicare, Medicaid, and/or other health insurance or third party plan and their respective agents any information needed to determine these benefits or related services.

Telephone and Alternative Communication Consent-I understand IMC-ESFP or its agents may use pre-recorded/artificial voice messages and/or auto dialing devices to remind me about appointments or notify me of other information and I expressly consent to IMC-ESFP or its agents use of any number associated with my account, including any wireless number. I also authorize IMC-ESFP or its agents to contact me at any number associated with my account, including wireless numbers, including contact by means of pre-recorded/artificial voice messages and/or automatic dialing devices, for the purposes of collecting on my account. I also authorize IMC-ESFP to communicate with me using any e-mail address I provide to IMC-ESFP.