

Welcome to Sound Family Health

Patient Information- Please Print

Date _____ Soc Sec# _____ Birthdate ___/___/___ Sex [] M [] F
Last Name _____ First Name _____ MI _____
Race _____ Language _____ Marital Status _____ Employer _____
Mailing Address _____
Street Number or P.O. Box _____ City _____ State _____ Zip _____
Primary Phone # _____ Alternate Phone # _____ Email _____

Spouse, Parent or Guardian Information- Please Print

Last Name _____ First Name _____ Sex [] M [] F
Birthdate ___/___/___ Soc Sec# _____ Relationship to Patient _____ Phone# _____

Primary Insurance Carrier- Please Print

Primary Ins. Carrier _____ Subscriber ID # _____ Group# _____
Subscriber's Name _____ Birthdate ___/___/___ Relationship to Patient _____

Secondary Insurance Carrier- Please Print

Secondary Ins. Carrier _____ Subscriber ID # _____ Group# _____
Subscriber's Name _____ Birthdate ___/___/___ Relationship to Patient _____

Financial Policy and Patient Signature of File

As a courtesy to all our patients, Sound Family Health will file a claim with your insurance company. However, this is not a guarantee of payment, therefore it is important for you to be aware of your insurance coverage, benefits and limitations. Ultimately, financial responsibility for services rendered rests with the patient or his/her guardian regardless of the nature or extent of the balance remaining after receipt of any insurance payment.

I have read, understand and agree to the financial policy as state above. I hereby authorize payment of medical benefits to Sound Family Health for any services furnished to me by a provider of Sound Family Health. I authorize the physician and clinic to release any information to process insurance claims. This authorization is in effect indefinitely.

Patient/Guardian Signature _____ **Date** ___/___/___

Patient/Guardian Printed Signature _____ **Date** ___/___/___

Private Pay Patients

I understand that payment in full is expected at the time of service. If I am unable to pay in full, I agree to contact the billing office to discuss payment options available, prior to my appointment.

Patient/Guardian Signature _____ **Date** ___/___/___

Medicare Recipients Only- Medicare Beneficiary Lifetime Authorization

I request that payment of authorized MEDICARE benefits be made to me or on my behalf to Sound Family Health for any services furnished to me by the providers. I authorize Sound Family Health to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Medicare Patient or Legally authorized individual

Date

**Sound Family Health
Privacy and HIPAA Form**

Last Name _____ First Name _____ Birthdate ____ / ____ / ____

Please CHECK all that apply:

Does the staff of Sound Family Health have your permission to leave messages in the effort to contact you regarding medical and/or financial information on your messaging system?

Primary Phone# _____ [] YES [] NO **
Alternate Phone# _____ [] YES [] NO **
Work Phone # _____ [] YES [] NO **
Email address _____ [] YES [] NO *

***Please be aware Emails are sent via Secure messaging only and could take up to 48hours; also do NOT send urgent/important emails. Please contact the office directly.**

****If "NO" is checked; ONLY the date, time and location of an appointment will be left on your messaging system.**

I give authorization to the staff of Sound Family Health to discuss my medical and/or financial information with the following people as needed or as it pertains directly to my care. This form may only be changed in writing; the amended form is available at the front desk.

1. _____
Name Relationship Primary Phone Number

2. _____
Name Relationship Primary Phone Number

3. _____
Name Relationship Primary Phone Number

Notice of Privacy Practices Acknowledgment

The Notice of Privacy Practices tells you how we may use or disclose your health record for the sake of your health care. It describes your rights with respect to your health records. Please read it, a copy is available at the reception desk and we can mail you a copy upon your request.

I acknowledge Sound Family Health's Notice of Privacy Practice.

Patient/Guardian Signature _____ Date ____ / ____ / ____

Patient/Guardian Printed Signature _____ Date ____ / ____ / ____

Treatment Authorization of Minors

I, the undersigned parent or guardian of _____ (patient's full name), grant permission and authorize medical care and treatment for the above mentioned minor, if minor should present to Sound Family Health without a parent or guardian.

Parent/Guardian Signature _____ Date ____ / ____ / ____

Parent/Guardian Printed Signature _____ Date ____ / ____ / ____