ATKINS FAMILY PRACTICE
1911 S. 17TH ST. SUITE 130-A
WILMINGTON, NC 28401
910-790-7840

TODAY'S DATE________________ CHART#____________________

PATIENT: ____
Last Name **First** **Middle Initial**

MAILING ADDRESS: ____

CITY: ______________________________________STATE__________ZIP__________

PHYSICAL ADDRESS: if different than above: ______________________________________

CITY: ______________________________________STATE__________ZIP__________

DATE OF BIRTH: ___/___/___AGE:______SEX:_____MARITAL STATUS:____________

HOME PHONE: (___)_____-_____CELL: (___)_____-_____WORK: (___)_____-_____

PATIENT SS#_____/_____/_____ GUARDIAN SS#_____/_____/_____

PARENT/GUARDIAN NAME: ___________________RELATIONSHIP:________________

PARENT/GUARDIAN ADDRESS: ____

CITY:______________________________________STATE:___________ZIP:__________

EMAIL_____________________________CAN WE COMMUNICATE WITH THIS METHOD?

YES___________________ NO______________________

PRIMARY INSURANCE: ___________________INSURED'S NAME:____________________

ID NUMBER: _________________GROUP#_____________INSURED'S DOB___/___/___

SECONDARY INSURANCE: ________________INSURED'S NAME:____________________

ID NUMBER: _________________GROUP#_____________INSURED'S DOB___/___/___

INSURED'S SOCIAL SECURITY # __________________________________

ATKINS FAMILY PRACTICE, PA
1911 S. 17TH STREET
SUITE 130-A
WILMINGTON, NC 28401
910-790-7840 FAX: 790-7828

Assignment of Benefits/Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to Atkins Family Practice, and any assisting physicians, or mid-level providers, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits.

AUTHORIZATION OF TREATMENT AND FINANCIAL RESPONSIBILTY

I do hereby give authorization to the medical staff of Atkins Family Practice to evaluate, treat, order labs and/or perform office procedures. I understand and agree that if I receive narcotics I am subject to random drug screenings. I also accept full financial responsibility (regardless of insurance payment or non-payment) for all charges incurred by myself or any person (s) I am responsible for. Account balances must be cleared prior to another appointment being scheduled unless prior arrangements have been made with the Office Manager.

Emergency Contact Information

Name of Emergency Contact Person: ____

Home Phone: ________________________ Cell Phone: ________________________

OFFICE POLICIES

A copy of our office policy is located in our waiting area. If you would like a copy of this policy please inform the staff at the front desk. In signing this agreement you agree to abide by all policies.

Do we have permission for the following:

To leave test results on your answering machine or with a family member?	YES	NO
To call you at work with test results or appointments?	YES	NO
To treat the patient if a minor?	YES	NO

SIGNATURE______________________________________ DATE______________

Atkins Family Practice
AUTHORIZATION

Purpose: This form is used to confirm the direction of an individual that we may use or disclose protected health information for a particular purpose.

I authorize the use and/or disclosure of my protected health information as described below. I understand that this authorization is voluntary and made to confirm direction.

Patient Name: ___________________________________
Address: ________________________________
Telephone: ___________________ Email: ______________________________
Patient Account #______________ Social Security# ______-______-______
Entities Authorized to Use or Disclose: **Name or specify the persons and/or organizations** who you are authorizing to make use of your protected health information: Ex: Spouse, children, significant other, other physicians.

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

Expiration and Revocation: This form will be enforced until further notice or death.

You may choose what information may be released to any of the above. For instance: only current illness and only for a certain period of time. You do not have to disclose any previous health issues. **This does not give the individuals listed the right to a copy of your medical records.** You will have a code word or phrase to access your information. We will not be able to give you any information over the phone without it.

Code Word: _______________________

I also give authorization for a copy of my lab results to be given to me after the results have been discussed with me by the provider or their medical staff.

Patient Signature: ____

I, _______________________________ have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form.

Signature: _______________________________ Date: ______________________

If this authorization is signed by a personal representative on behalf of the individual or minor, complete the following:
Personal Representative's Name: _______________________________________
Relationship to Individual: ______________________________________
YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT. A COPY OF THIS WILL BE KEPT IN YOU MEDICAL RECORDS.