MERCY FAMILY MEDICINE OF CORALVILLE

Demographic Sheet

PATIENT DEMOGRAPHICS (PROVIDE PHOTO ID TO SCAN)

FULL NAME (F MI L)		WORK STATUS		HOME PHONE	
SSN		EMPLOYER		CELL PHONE	
GENDER		ADDRESS		WORK PHONE	
DOB		ZIP CODE		Primary Care Provider	
MARITAL STATUS		CITY		REFERRAL SOURCE ❑Employer ❑Friend ❑Hospital ❑Mail ❑Newspaper ❑Radio ❑Provider ❑TV ❑Relative ❑Internet ❑Other:	
RACE	ETHNICITY ❑Other ❑Hispanic or Latino	STATE			
FIRST LANGUAGE		E-MAIL ❑None			
PATIENT'S PHARMACY		PATIENT'S MOTHER'S MAIDEN NAME			

GUARANTOR (FINANCIAL RESPONSIBLE)

RELATION TO PATIENT ❑Self ❑Husband ❑Wife ❑Child ❑Parent ❑Other				HOME PHONE	
FULL NAME (F MI L)		ZIP CODE		CELL PHONE	
SSN		CITY		WORK PHONE	
GENDER		STATE		WORK STATUS ❑Retired ❑Student ❑ Full-time ❑Part-time ❑Unemployed	
DOB		EMPLOYER			
ADDRESS ❑Same as above		E-MAIL ❑*None*			

INSURANCE (PROVIDE CARD(S) TO SCAN)

PRIMARY INSURANCE		SECONDARY INSURANCE	
GROUP #		GROUP #	
POLICY #		POLICY #	
EMPLOYER PLAN		EMPLOYER PLAN	
PATIENT'S RELATION TO INSURED ❑Self ❑ Husband ❑Wife ❑Child ❑Parent ❑Other:		PATIENT'S RELATION TO INSURED ❑Self ❑ Husband ❑Wife ❑Child ❑Parent ❑Other:	
INSURER'S FULL NAME		INSURER'S FULL NAME	
DOB		DOB	
HOME PHONE		HOME PHONE	

EMERGENCY CONTACT

FULL NAME (F MI L)		CONTACT LANGUAGE		WORK PHONE	
RELATION TO PATIENT		HOME PHONE		CELL PHONE	

HEALTH INFORMATION

PREFERRED PHONE NUMBER ❑ Home ❑ Work ❑ Cell ❑ Other:	PATIENT'S RELATION TO PERSON ❑ Husband ❑Wife ❑Child ❑Parent ❑Other:
MAY WE DISCUSS HEALTH INFORMATION WITH ANOTHER PERSON? ❑ No ❑ Yes IF YES, NAME (F MI L):	IF YES, WHAT TYPE: ❑ Billing/Financial ❑ Scheduling/Appointments ❑ Medical/Treatment/Diagnosis

POLICY ACCEPTANCE

1. CONSENT FOR TREATMENT AND RELEASE FROM RESPONSIBILITY. Patient being informed that patient may be suffering from a condition that requires clinic services, diagnosis, and medical or surgical treatment, does voluntarily consent to and authorize clinic services, including laboratory and x-ray procedures, and medical and surgical treatment as patient's physician, including his / her assistants and designees, may deem necessary. Patient acknowledges that no guarantees have been made to patient or anyone else on patient's behalf, as to the results of such services and procedures.

2. RELEASE OF INFORMATION. Mercy Clinics may disclose medical information including mental health information, alcohol and/or drug abuse information and HIV/AIDS information, related to the patient's diagnosis and treatment to any person or corporation that may be liable under a contract to the clinic, patient, patient's family member, or patient's employer for all or part of the charge for the purpose of processing the claim. This includes, but is not limited to the Industrial Commission, workers' compensation carriers,self-insured organizations, mutual hospital associations, insurance companies, health maintenance organizations, Medicare and its agents, and Medicaid and its agents, and utilization review or managed care organizations for the purpose of utilization, quality, and coverage review. Patient also authorize the release of information about patient's health status, including mental health information, alcohol and/or drug abuse information and HIV/AIDs information, for continuing health care services. Patient understands that patient may review the disclosed information at any time and that this consent expires one year from this date, although patient may revoke this consent by notifying Mercy Clinics in writing of such revocation.

3. CONSENT TO RECORDING OR FILMING. Patient understands that recording or filming (including photographic, video, electronic, digital, or audio media) may be done to document patient's care and treatment. Patient consents to this use of recording or filming for internal organizational purposes, such as performance improvement and education. Patient has the right to request cessation of the recording or filming. Patient has the right to rescind patient's consent for the use of any recording or filming up until a reasonable time before its use.

4. PERSONAL VALUABLES. The clinic shall not be liable for the loss or damage of any money, jewelry, dentures, documents, articles of usual value or other personal property.

5. FINANCIAL AGREEMENT. Patient agrees to pay for services rendered. The account is to be paid in full at time of discharge or upon billing unless credit arrangements satisfactory to the clinic are made. Insurance assignments will be accepted in lieu of cash for the amount covered by insurance. Should the account be referred to any attorney for collection, the patient shall pay reasonable attorney's fees and collection expense. In order for us to service our account and/or collect any amounts you may owe, you hereby agree and consent to all of the following: (1) our contacting you by telephone at any one or more telephone numbers associated with your account, including wireless telephone numbers, which could result in charges to you; (2) our sending you text messages or e-mails, using any telephone number or e-mail address you provide us; (3) means for communicating with you may include pre-recorded messages, artificial voice messages, and/or automatic dialing systems and similar devices; and (4) we may leave a message or pre-recorded message on your answering machine and/or voicemail system. You further hereby agree that these consents and agreements are applicable to Mercy Clinics and to our representatives and agents.

6. ASSIGNMENT OF INSURANCE BENEFITS. Patient requests payment of Medicare benefits on patient's behalf for any services furnished patient by or in Mercy Clinics, including physician's services. Patient assigns to Mercy Clinics any medical benefits from any policy insuring the patient or any other party liable to the patient for application on the patient's bill. Patient also assign to patient's physicians any benefits for physician services. Patient agrees that any such payment shall discharge the insurance company of obligation under the policy to the extent of such payment, the patient being responsible for charges not covered by this assignment.

7. CONSENT FOR USE OF PRESCRIPTION HISTORY. Patient consents to the clinics use of prescription history. The use of this protected health information (PHI) is for reference concerning treatment, payment, or operations.

8. Unless otherwise provided by law, in the case of a minor a parent shall sign and be obligated hereunder on behalf of the patient.

PATIENT UNDERSTANDS THAT IT IS PATIENT'S RESPONSIBILITY TO OBTAIN TREATMENT AUTHORIZATION IF REQUIRED FOR INSURANCE COVERAGE.

_____ _____ _____

Patient's or Patient's Representative on behalf of Patient Signature | Date | Patient Representative's Relationship to Patient

Patient unable to sign
due to condition/ _____
Staff Signature / Date