Abundant Health Family Practice

Dr. Cynthia Elliott DNP,FNPC

Existing Patients
Please revise all information that has changed since your last visit.

Date___/___/_____ ____New Patient ____Existing Patient

Last Name_____First Name_____MI____ Cell #_____

Email Address_____Home #_____Work#_____

Street Address_____City _____State_____Zip_____

Mailing Address_____City_____State_____Zip_____

Gender: Male____Female____ SSN:_____-____-_____ Date of Birth_____/_____/_____

Circle One: Married – Single – Partnered – Widowed Name of Spouse/Partner/SO_____

Patient Employed by_____

Business Address_____

Business Phone_____ Occupation_____

Name of Spouse_____Social Security#_____-_____-_____
Last First MI

Name of Responsible Party_____SS#_____-_____-_____
(if patient is a minor) Last First MI

Spouse/Resp. Party Employer_____

Business Address_____City_____State_____Zip_____

Business Phone_____Occupation_____

Do you have medical Insurance? ____Yes ____No If yes, please complete the following:

Name of **Primary Insurance**_____ID#_____Group#_____

Subscriber's Name_____Date of Birth_____/_____/_____
This information is required by HIPAA

Insurance Address_____City_____State____Zip_____

Name of **Secondary Insurance**_____ID#_____Group#_____

Subscriber's Name_____Date of Birth_____/_____/_____

Insurance Address_____City_____State_____Zip_____

In case of an emergency, who should be notified?_____

Relationship_____Phone_____

Preferred Pharmacy_____How did you hear about us_____

Assignment of Insurance Benefits

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature of this document authorizes my provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I_____, hereby authorize_____
(Name of Insured) (Name of Insurance Company)

to pay and hereby assign directly to Dr. Cynthia Elliott DNP, FNPC all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for charges incurred if for some reason my insurance has lapsed, I am un-insured, or the treatment/procedure is not covered by the insurance plan. I further acknowledge that any insurance benefits, when received by and paid to Dr. Cynthia Elliott will be credited to my account, in accordance with the above said assignment.

_____ Date_____
(Authorized Signature of Subscriber)

Medicare Authorization

IF YOU ARE COVERED BY MEDICARE, PLEASE SIGN AND DATE BELOW

I request payment of authorized Medicare benefits be made either to me or, on my behalf to Dr. Cynthia M. Elliott, DNP, FNPC / Abundant Health Family Practice for any services furnished to me by AHFP. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the health care provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the **deductible, co-insurance, and non-covered services**, Co-Insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Signature of Beneficiary Date

Financial Policy: I have read and understand the financial policies of Abundant Health Family Practice. By my signature I agree to the terms outlined in the financial policies.

Signature_____ Date_____

Consent for Treatment: I (or my legal guardian/parent) authorize Abundant Health Family Practice to provide medical care reasonable to today's standards.

Signature Patient/Legal Guardian_____ Date_____