THERAPIST	ACCOUNT #	DX	PAYMENT

Preferred Family Clinic

Patient Information

PATIENT'S LEGAL NAME ***WRITE LEGIBLY***

Last Name	First Name		Middle Initial
Street Address	**City**	**State**	**Zip**
Birthdate / **Sex**	**Social Security Number**		**Marital Status:**
Employer	**Preferred Phone:**	Choose one: ☐ TEXT ☐ CALL	**Other Phone:**

For courtesy appointment reminders, we will use your ***preferred phone number*** and text you if no box is checked.

E-mail:_____

CIRCLE ONE: **WIFE/ *MOTHER/ *GUARDIAN (*Information required for all minors)**

Last Name	First Name		Initial
Street Address	**City**	**State**	**Zip**
Marital Status / **Sex**	**Birthdate**	**Age**	**Cell Phone:**
Social Security	**Employer**		**Other Phone:**

CIRCLE ONE: **HUSBAND/ *FATHER/ *GUARDIAN (*Information required for all minors)**

Last Name	First Name		Initial
Street Address	**City**	**State**	**Zip**
Marital Status / **Sex**	**Birthdate**	**Age**	**Cell Phone:**
Social Security	**Employer**		**Other Phone**

PATIENT'S NEAREST RELATIVE (NOT LIVING WITH PATIENT)

Full Name	Relationship to Patient
Address	**Phone:**

Who referred you to Preferred Family Clinic? Or how did you hear about us? _____

Who is the patient's primary care physician? _____

Is the patient on any medication?_____Yes_____No.

If so, name of medication(s) _____

CREDIT / DEBIT CARD TO BE KEPT ON FILE-OPTIONAL

Name (as it appears on the card)		Billing Zip Code / State
Card Number	**Expiration Date**	**Security Code (CVV)**

**** PLEASE COMPLETE **BOTH** SIDES OF THIS FORM****

RESPONSIBLE PARTY (Signature Required)

Last Name	First Name		Initial
Street Address	City	State	Zip
Marital Status	Birthdate	Age	Home Phone
Social Security	Employer		Other Phone

PRIMARY INSURANCE

Name of Insurance Company		Insurance Company Phone
Insurance Company Address		Subscriber's Relationship
Subscriber's Name		Subscriber's Birthdate
Subscriber's Social Security #	Policy #	Group #
Subscriber's Employer		Work Phone

SECONDARY INSURANCE

Name of Insurance Company		Insurance Company Phone
Insurance Company Address		Subscriber's Relationship
Subscriber's Name		Subscriber's Birthdate
Subscriber's Social Security #	Policy #	Group #
Subscriber's Employer		Work Phone

Please read and initial:

I, the undersigned, acknowledge I have received and read a copy of the Payment Policy for Preferred Family Clinic. I assume full responsibility for payment of this account. I recognize the provider cannot accept responsibility for collecting any insurance claim. I also agree in the event of default in the payment of any amount due, and if this account is placed in the hands of an agency or attorney for collection of legal action, to pay an additional charge equal to the collection costs including agency and attorney fees and court costs incurred and permitted by laws governing these transactions. A finance charge or 3.0 percent per month (annual rate of 36 percent) may be charged on all balances over 30 days regardless of pending insurance claims.

_____ **(Initial)**

I acknowledge that I have seen and reviewed a copy of Preferred Family Clinic's *Notice of Privacy Practices.* I know that I can request a written copy of this written notice for my own use.

_____ **(Initial)**

I, acknowledge that I am responsible and liable for the actions of anyone I bring to Preferred Family Clinic. This includes behavior in the waiting room, therapy room, or anywhere else on the property of Preferred Family Clinic.

_____ **(Initial)**

I agree to pay for such services at the rates posted on Preferred Family Clinic's current rate schedule. If the patient is, or will be, a qualified Medicaid recipient, I agree to assume payment responsibility for those services which exceed program benefits or are unauthorized by Medicaid.

_____ **(Initial)**

I, the undersigned, give consent to Preferred Family Clinic and its clinicians to render professional services to the above named patient. I understand some services may be rendered by residents, interns, or other paraprofessionals in training. If I or my insurance company objects to the rendering of services by such personnel, I will notify the clinical director in writing before such services are rendered.

_____ **(Initial)**

I, the undersigned, give permission to release information to 3rd party carrier(s) and do assign all insurance benefits for treatment to be paid directly to Preferred Family Clinic and request this assignment remain on file with my insurance carrier. I certify a copy of this assignment shall be as valid as the original.

_____ **(Initial)**

I, the undersigned, wish to keep my Credit or Debit Card number on file for my added convenience. Furthermore, I have filled in the corresponding section on this form and understand payment will be charged to this card at the time of service.

_____ **(Initial)**

I, the undersigned, give permission to Preferred Family Clinic to discuss appointment times and billing questions regarding this account with members of my immediate household unless I notify Preferred Family Clinic of my objection in writing.

_____ **(Initial)**

_____ _____

Date **Signature of Patient, Guardian, or Guarantor**