

Chart #: office use only Date: _____
Patient's Name: _____
Address: _____ Apt#: _____
City: _____ State: _____ Zip: _____
Referred by: _____
Patient employed by: _____
Business address: _____
City: _____ State: _____ Zip: _____

E-mail address: _____ @ _____
Social security #: _____ - _____ - _____
Date of Birth: MM / DD / YYYY
Sex: Male Female
Marital Status: Single Married Widowed Divorced
Employment Status: Employed Not employed Student
Home Phone#: _____ (_____) _____ - _____
Business Phone#: _____ (_____) _____ - _____
Cell Phone#: _____ (_____) _____ - _____

PRIMARY INSURANCE CARDHOLDER (IF OTHER THAN PATIENT)

Name: _____
Address: _____ Apt#: _____
City: _____ State: _____ Zip: _____
Relationship to patient: _____

Social security#(required): _____ - _____ - _____
Date of Birth (required): _____ / _____ / _____
Home Phone#: _____ (_____) _____ - _____
Business Phone#: _____ (_____) _____ - _____
Cell Phone#: _____ (_____) _____ - _____

PRIMARY MEDICAL INSURANCE INFORMATION

Please present your insurance card at the front desk

Insurance Company: _____
Insurance ID#: _____
Group #: _____

SECONDARY MEDICAL INSURANCE INFORMATION (IF ANY)

Insurance Company: _____
Insurance ID#: _____
Group #: _____

EMERGENCY CONTACT

Name of relative not living with you: _____ Home Phone: _____ (_____) _____ - _____
Relationship: _____ Business Phone: _____ (_____) _____ - _____
Cell Phone#: _____ (_____) _____ - _____

CITY CARE FAMILY PRACTICE OFFICE POLICIES:

In order to serve all our patients equally, please understand the following:

- We do not accept workers' compensation (work injury) nor Nofault (car accident) insurances. If you have visit related to any of these conditions, full payment is expected at the time of service.
- A **\$50 fee** will be charged for missed appointments without a 24 business hour notice. (as of 1/1/07)
- A **\$25 fee** will be charged for the reissue of prescriptions and medication/refills not prescribed during a visit.
- Late appointments for more than 30 minutes will be rescheduled.
- If a referral is required, please give us a **24 business hour notice**. We **do not** backdate a referral.
- You are responsible to inform us of any address and phone number changes.
- Payment is expected at the time of service.
- **We do not accept personal checks.** We only accept cash, major credit cards and money order.
- If payment is not received by the due date, your account may be forwarded to an agency to help us collect the outstanding balance.
- Patient's aged 17 and under must be accompanied by a parent/guardian during their visit, unless the child has an issue regarding sexuality/contraception.
- **Blue Cross/Blue Shild insurance subscribers:** We do **not** accept Healthpay Plus Cards by American Express.

I hereby authorize City Care Family Practice, P.C. to furnish information concerning my illness and treatment to my insurance carriers, physicians to whom I am referred, and to health care facilities where I receive care. I authorize payment of medical benefits to City Care Family Practice, P.C.

I understand that I am responsible for my benefit coverage and agree to pay any charges that are not covered b my insurance carriers.

I have read and I understand the office policies of City Care Family Practice, P.C.

Authorized Signature

Date

I have received the "I wanna have a check up" brochure which notifies me of recommended tests by age & sex. Initial: _____