Patient Information		
Last Name:	First Name:	MI:
Mailing Address:		
City/State/Zip:		
Home:	Cell:	Work:
Date of Birth:	Sex M___ F____	Marital Status: S ___ M____ W___ D____
Social Security #		
Employer Name:		Contact:
Emergency Contact Name:		
Relationship to Patient:		Emergency Contact Phone # :
Responsible Party– If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as guarantor:		
Last Name:	First Name:	
Date of Birth:	Social Security#	Phone:
Address of Responsible Party		
City/State/Zip		
Patient Additional Information (Please Complete All Sections Below)		
Email Address:		
Preferred Language: __ English ___Spanish ___ Indian ___ Russian ___ Sign Language ____ Other		
Preferred Pharmacy Name:		
Pharmacy Number:		

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holders DOB:	Policy Holders DOB:
Relationship to Patient:	Relationship to Patient:

MEDICAL HISTORY

Patient Name: _____ **Date of Birth:** _____

Medications

Medication Name	Dose	Medication Name	Dose

Surgical History

Year	Surgery

Allergies

Ingredient/Allergen	Reaction

Family History

Family Member	Age	Diagnosis
Mother		
Father		
Sister		
Sister		
Brother		
Brother		
Other		
Other		

PATIENT FINANCIAL & PAYMENT POLICY

Patient Name: _____ Date of Birth: _____

This financial payment policy is an agreement between Crossroads Family Clinic, LLC. And you, the patient, or responsible party. By signing this form, you are acknowledging that you understand and agree to our financial payment policy.

Patient Responsibility:

- You must provide us with current insurance card and billing information. Your insurance policy is a contract between you and the insurance company. It is your responsibility to know your insurance benefits. We will bill insurance plans, but we do not guarantee coverage. We will bill you for any remaining portion due after insurance processes your claim.
- **Co-Pays** are due at the time of service. (We can take cash, checks and credit/debit card.)
- **Return Check Fee:** Any check that are returned to us will be charged $30 fee and will no longer be able to use checks for payment.
- **No show/ Late Cancellation fee:** Any patient who no shows or does not cancel with 24 hours of appointment time, will be charged a $25 cancellation fee.
- **Outstanding balances:** Any balances that are more than 90 days old will need to be paid in full before appointments can be scheduled.

I understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any deductible, co-insurance, copay or any service(s) deemed a "non-covered benefit" by my insurance company. I understand that failure to pay outstanding balances within 90 days of receiving my first statement will result in submission of my account to an outside collection agency. If the debt remains after transfer to our outside collection agency, the debt may be reported to credit bureaus and your credit rating may be affected. In addition, failure to pay delinquent account balances may result in termination of care from Crossroads Family Clinic, LLC.

X_____ **Date** _____

Signature of Patient or Guarantor

_____ _____

Printed name of Representative **Relationship**

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form upon your request.

QUESTIONS AND COMPLAINTS

To learn more about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may contact us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Acknowledgement: I hereby acknowledge that I have read and fully understand the contents of this document, and I have been given the opportunity to ask any and all questions.

May we phone, email, or send a text to confirm your appointments?	Yes	No
May we leave a message on your voice mail/ answering machine Asking you to call us back?	Yes	No
May we leave a detailed message on your voice mail/ answering Machine with results or referral information?	Yes	No

In order to help us stay within the guidelines of HIPPA, please list below any person/persons that you authorize us to disclose information to regarding your Protected Health Information, (PHI). This includes but not limited to medications, appointment information and billing questions.

I, the patient, authorize Crossroads Family Clinic, LLC. to discuss my medical records with the following:

	Name	Phone	Relationship
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

*By signing below, I acknowledge that I have read and understand this practices Notice of Privacy Practices

Patient or Guardians Signature: _____ Date: ____/____/_____

If patient is a minor,

Guardian's relationship to patient: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

PATIENT NAME:_____ **Date of Birth:** _____

Contact: (H)_____**(C)**_____ **(W)**_____

Address: _____

City/State/Zip: _____

PLEASE NOTE: COPY FEE MAY BE CHARGED FOR MEDICAL RECORDS

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____

Facility Address: _____

City/State/Zip: _____ **Facility Phone:** _____

Dates and Type of information to disclose:

___ 2 Years prior from last date seen
___Specific Information Requested

___ All Records

The Purpose of Disclosure is:

___ Change of Insurance or Physician
___ Continuation of Care (e.g. VA Med Ctr)

___ Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

This information may be disclosed and used by the following individual or organization:

Release To: Crossroads Family Clinic, LLC.

Address: 75 County Road 576 City/State/Zip: Rogersville, AL 35652

Phone: 256-802-2240 Please Fax all records under 20 pages Fax: 256-802-2241

Please Mail 20 or more pages

I understand I may revoke this authorization at any time, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this Authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do herby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ Date: _____

_____ _____

Printed Name of Authorized Representative Relationship/ Capacity to patient