Date:________________

Demographic/HIPAA Form

Name:____
FIRST MI LAST

Home Phone:______(______)______________________ Cell Phone:______(______)______________________

Work Phone:______(______)______________________ Email Address: ______________________

Home Address:____
STREET APT # CITY STATE ZIP

DOB:____________________ Age:__________ Sex:__________ Social Security #:____________________

Emergency Contact Name:____________________ **Relationship:**____________________ **Phone:** (______)______________

Emergency Contact Name:____________________ **Relationship:**____________________ **Phone:** (______)______________

Is the patient a minor? Yes No **Is the patient an adult dependent?** Yes No

Are you employed? Yes No Full-Time Part-Time Self Employed Retired

Are you a student? Yes No Full-Time Part-Time

Marital Status: Single Married Divorced Widowed

***Please tell us how you heard about our office:**

____

Employer:______________________________________ Employer Phone: (______)______________

Please provide the names and contact information of your current medical providers beginning with the physician who referred you to us:

____________________ ____________________ (______)______________
REFERRING PHYSICIAN NAME **TYPE OF PROVIDER** **PHONE NUMBER**

____________________ ____________________ (______)______________
PHYSICIAN NAME **TYPE OF PROVIDER** **PHONE NUMBER**

____________________ ____________________ (______)______________
PHYSICIAN NAME **TYPE OF PROVIDER** **PHONE NUMBER**

PLEASE PROVIDE THE RECEPTIONIST WITH YOUR INSURANCE CARDS AND PHOTO I.D.

PRIMARY INSURED INFORMATION IF NOT THE PATIENT:

Name:____ Relationship:____________________
FIRST MI LAST

DOB:____________________ Age:__________ Sex:__________ Social Security #:____________________

Address:____
STREET APT # CITY STATE ZIP

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION AND MEDICAL RECORDS / CONSENT TO TREATMENT / APPOINTMENT OF AUTHORIZED REPRESENTATIVE / NOTICE OF PRIVACY PRACTICES

PLEASE INITIAL NEXT TO THE FOLOWING FOUR STATEMENTS

________ I hereby authorize payment directly to the physician of surgical and/or medical benefits, if any otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

________ I hereby authorize the physician to release any information and/or medical records acquired in the course of my treatment necessary for my treatment or to process insurance claims to doctors, nurses, or other medical personnel who are involved in my care.

________ I hereby give my consent for medical treatment by the physician to myself or dependent.

________ We are committed to securing the privacy of your health information. We are supplying you with our Notice of Privacy Practices. You are not required to read this notice. By initialing, you are acknowledging receipt of this notice.

____ ____________________
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES
AND REVIEW OF
PATIENT RESTRICTION OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

I have received and reviewed Family Physicians of Richardson **Notice of Privacy Practices**, which explains how my Individually Identifiable Health Information (IIHI) may be used or disclosed. IIHI is the same as my medical information. I have also received a copy of this **Acknowledgment of Review and Patient Restriction of Protected Health Information**. I can fill in the names of friends, relatives, spouse, immediate family, etc. below if I want them to be able to have access to my IIHI. I understand that my Primary Care Physician will be provided access to my IIHI unless otherwise noted below.

I am confirming receipt of this Acknowledgment of Review of Privacy Practices and identifying who has access to my IIHI, other than myself. Please check below.

☐ I do not want anyone to have access to my IIHI. I am the only one who should have access to my IIHI.

☐ It is agreed and acceptable for my "spouse only" to have access to my IIHI.

☐ Patient is under eighteen (18) years of age and understands that his/her legal representative has access to his/her IIHI and the legal representative is signing below.

☐ I want the person/s listed below to have access to my IIHI:

Name: ______________________________ Relationship: ______________

Name: ______________________________ Relationship: ______________

☐ do not want my Primary Care Provider to have access to my IIHI.

☐ It is acceptable to leave a detailed, medical phone message for me at the following number:

(______) ______________________________ ☐ Home ☐ Work ☐ Cell

____
Printed Name of Patient

____
Signature of Patient **IF NOT A MINOR**

____
Signature of Personal/Legal Representative **IF PATIENT A MINOR**

____
Personal/Legal Representative's Relationship to Patient

Date ______________________

Physician Signature ______________________________

____
Signature of Compliance Officer for Family Physicians of Richardson