MORRIS FAMILY HEALTHCARE & WELLNESS

PATIENT DEMOGRAPHIC ~PERSONAL INFORMATION

____
Last Name First Name Middle Initial Date

____
Birth Date Sex Marital Status

____
Address City State Zip Code

Home Phone: ______________________ Ok to leave a **detailed** message? YES/ NO

Cell Phone: ______________________ Ok to leave a **detailed** message? YES/ NO

Work Phone: ______________________ OK to leave a **detailed** message? YES/ NO

Whom may we release medical information to?

____
Name and Relationship Phone

____
Name and Relationship Phone

Emergency Contact:

____
Name and Relationship Phone

Power Of Attorney for Healthcare:

____
Name and Relationship Phone

Ethnicity: Caucasian Asian American-Indian African-American Hispanic Other ____________

Parent/Guardian Address if different than Patient:

____
Name and Relationship Phone

____
Address

PLEASE COMPLETE BOTH SIDES

MORRIS FAMILY HEALTHCARE AND WELLNESS

____

Last Name First Name Middle Initial Date

PHARMACY

____

Local Pharmacy Name City

____

Mail Order Pharmacy Name Contact Information

PATIENT DEMOGRAPHIC~FINANCIAL INFORMATION

____

Primary Insurance Secondary Insurance

We are committed to providing you quality and affordable health care. Your clear understanding of our Financial Policy is important.

Initial Each Statement To Indicate Your *Understanding* Of The Policies You Will Be Responsible For
<u>Effective January 1, 2017 Failure to initial DOES NOT negate your C*ompliance,*</u>

________ **Returned Checks** A $35 charge will be applied to all returned checks in addition to amount of check.

________ **Guarantee of Payment ALL COPAYS MUST BE PAID AT THE TIME OF SERVICE.** I guarantee payment of all charges not paid by insurance, I understand that all bills are payable and become due upon presentation.

________ **Missed Appointments** All appointments cancelled less than **one hour prior** to the appointment time will be considered a no show.

________ **No Show Appointments** will result in a $35 charge *to the patient*. Three no show appointments in a 12 month period may result in discharge from the practice. Please help us to serve you better by keeping your scheduled appointment.

________ **Insurance** I authorize Morris Family Healthcare & Wellness to release medical information necessary to process claims. **You will be asked to provide us with your insurance card(s) at EACH visit.**

________ **Fees and Payments** I understand that I am responsible for all charges not covered by insurance. I agree to pay al collection costs incurred, fees for litigation, attorney and court costs. If you are not insured by a plan we do business with, payment in full is expected at each visit unless prior arrangements have been made.

________ **Fees for Paperwork** Forms completed during your appointment are considered part of your visit and are included at no additional extra cost. Due to an increased volume of requests for paperwork **outside** of office visits, you may be charged a small fee for completion of forms done **outside** office visits. See *Documentation Fee Form* for further information.

I acknowledge that I have read and agree to this Financial Policy

____

SIGNATURE Date

PLEASE COMPLETE BOTH SIDES