# Patient Information Sheet
**PLEASE PRINT**

**Your name** ____________________________ ______________________ ______________________
**Last** **First** **Middle**
**DOB**____/____/____ **Sex** ___ Male ____ Female **Marital Status:** Single Married Other (please circle)

Home Address ___________________________________________________City: ___________________State:_____, Zip____________

Employer Name_________________________________ Primary phone ___________________ Secondary phone _________________

Work phone ___________________Preferred Pharmacy____________________________________________________________________

Email address:_____________________________________________________ (required for secure messaging / patient portal)
*Appointment reminders will now be done through your patient portal.* **Contact Preference: email or phone (cell, home, work)**

**Ethnicity:** (circle) *White/Caucasian* *White Hispanic/Latin* *Black/African American* *Black Hispanic/Latin* *Asian* *American Indian* *Alaskan Native* *Native Hawaiian or other Pacific Island Native* *Other* *Refused*

**Language Preference:** __ English __ Other: ___________________ **Barriers To Communication:** Vision Hearing

Concerning children under the age of **14:** ___________________________________________, has my consent to authorize treatment

of said minor child in my absence. Signature of legal guardian: __________________________________________________________

Who should we call in case of an emergency? Name___________________________ Relationship ________Phone ___________

**I authorize the release of my medical information to**: (family member or friend )

_____________________________________________________________________________________________________________________

**ALL PATIENTS OVER THE AGE OF 14 MUST SIGN FOR THEMSELVES UNLESS WE HAVE A POWER OF ATTORNEY ON FILE.**

Are other family members patients here? Y N If yes, please list name(s) __________________________________________________
Who referred you to the practice? Family member Friend Internet Phone book Other: ______________________________

**Primary Insurance Company** _____________________________________________________________________

Contract Number ___________________________________ Group Number ______________________________ Co-pay $ _________
Insurance Address: _____________________________________________________________ Insurance Phone: ____________________
Policy Holder Name _________________________________ Policy Holder DOB _______________________________
How are you related to the policy holder? Self Spouse Child Other ( ______________________________)

**Secondary Insurance Company** ____________________________________________________________________

Contract Number ___________________________________ Group Number ______________________________ Co-pay $ _________
Insurance Address: _____________________________________________________________ Insurance Phone: ____________________
Policy Holder Name _________________________________ Policy Holder DOB _______________________________
How are you related to the policy holder? Self Spouse Child Other ( ______________________________)

**I, the undersigned, authorize payment of medical benefits for any services furnished to me by my practitioner. I understand that I am financially responsible for any amount not covered by my insurance. I understand that I am required to pay all co-pays, deductibles or non-covered services at the time of service.**

Date _____/_____/_____ Signed _________________________________________________________________

____________________________________________ __________________________________________________
Printed Name of Parent or Guardian Signature of Parent or Guardian

**Patient Consent Form: Patient Consent for Use and Disclosure of Protected Health Information**

**Kara Wallace, M.D.**
**Anna Adams, CRNP**
**Courtenay Simmons, CRNP**

I hereby give my consent for the above named physician and/or practitioner to use and disclose protected health information (PHI) about me to carry out Treatment, Payment and health care Operations (TPO). (The Notice of Privacy Practices provided me by the above named physician and/or practitioner describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices; located in patient waiting room, prior to signing this consent. The above named physician and/or practitioner reserve the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer for the office, Karen Anthony.

With this consent, the physician, practitioner and their staff may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results among others.

With this consent, the practice may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, lab results; as long as they are marked "Personal and Confidential", patient recall letters and patient statements.

I have the right to request that the practice restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow the practice to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it the practice may decline to provide treatment to me.

Signed by: ____________________________________ Date ____/____/____

____________________________________________ ____________________________________

Print Patient's Name Print Name of Legal Guardian, if applicable

A signed copy of this authorization must be placed in patient's medical file.

DO NOT DESTROY

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