

Russell A. Smith, MD Alicia Jones, MD Andrea G. Southerland, NP

PATIENT INFORMATION

TODAY'S DATE: _____

Patient Name: _____ Birthdate: _____

Address: _____ Apt # _____

City, State, Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Which is best contact: (*circle*) CELL HOME WORK

Race/Ethnicity: _____ Employer/Occupation: _____

Preferred Pharmacy: _____ Approx. Address & City: _____

Marital Status: (*circle*) Single Married Separated Divorced Widowed Other: _____

Spouse's Name: _____ Birthdate: _____

Who referred you to our office? _____

Who, besides yourself, can we release information to: _____ Relation _____

If a patient is a *minor*, who can receive information? Name: _____

Relation: _____ Phone Number: _____

Name of Person to contact in case of emergency:

Name: _____ Phone Number: _____ Relation: _____

INSURANCE INFORMATION

***** Please fill out completely, and give cards and picture ID to front office staff**

Primary Insurance: _____ Policy Holder: _____

Policy Holder's Birthdate: _____ Relationship to Patient: _____

ID #: _____ Group #: _____

Secondary Insurance: _____ Policy Holder: _____

Policy Holder's Birthdate: _____ Relationship to Patient: _____

ID #: _____ Group #: _____

*****TURN OVER*****

PLEASE CIRCLE YOUR PROVIDER:

RUSSELL A SMITH, MD ALICIA JONES, MD ANDREA SOUTHERLAND, FNP

Patient Name: _____ Date of Birth: _____

Please **INITIAL** that you have received each of these items:

_____ **Consent to treat:** I have read the consent to treat and fully understand its contents.
Initial here

_____ **Consent to EMAIL or TEXT:** I give consent to email or text appointment reminders or
Initial here other healthcare communications.

_____ **Notice of privacy Practices:** I have read the privacy notice and understand the content.
Initial here

Lab Consent Policy

I understand that our providers nor any of their staff know what my exact insurance benefits are for labs.

I understand that I am responsible to call about my coverage if I am concerned about what will be covered.

I understand that my provider will order what they feel is medically necessary based on our visit. If I choose to not have this lab work done they may not be able to treat me. I am aware that I will be responsible for the charges that are not covered by my insurance. I further understand that the office will not add or change codes after labs are drawn if there is no documentation to support this.

Initial here

Payment Policy:

Our office, as a courtesy to you, will bill your insurance carrier for the service performed by Dr. Russell Smith, Dr. Alicia Jones, Miquelle Smith and Andrea Southerland, or any nursing staff. Co-Pays are requested at the completion of each visit if applicable. If you do not have insurance, please discuss your payment needs with the office manager.

I also hereby authorize the release of any medical information necessary to process insurance claims. I hereby assign and transfer any insurance benefits due to me to them. I understand I am financially responsible for any unpaid balance on my account after insurance payments and adjustments.

It's understood and agreed that if I fail to pay for my account in accordance with these terms, I will pay all costs of collection, including reasonable attorney fees, court costs and up to 50% collection fee.

I have read and understand the financial and Lab policy of this office.

Signed: _____ Date: _____

Parent/Guardian of Minor: _____ Print Name: _____