GUNNISON VALLEY FAMILY PHYSICIANS

CERTIFIED AMERICAN BOARD OF FAMILY PHYSICIANS

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PATIENT INFORMATION

Date _____ Soc. Sec.# _____ Birthdate _____

Patient's Full Legal Name _____
(First M. Last) (Nickname)

Local Mailing Address _____
City ST Zip

Email Address _____ I prefer contact via: ☐Phone ☐Email ☐Mail Language Preference: _____

Please check preferred contact phone ☐ Home _____ ☐ Work _____ ☐ Cell _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed

Race: ☐White ☐Black ☐Asian ☐Indian ☐Alaskan ☐Pacific Isle ☐Hispanic ☐Other: _____ Ethnicity: ☐Hispanic ☐Non-Hispanic

Emergency contact? Name _____ Relationship _____

Address _____
Street Address City ST Zip

Phone _____

CONTACT INFORMATION

* COLLEGE STUDENTS MUST PROVIDE PARENT'S INFORMATION.

Guarantor The person signing this form will be noted in our records as the "Guarantor" of the account. As such, they will receive financial statements from our office. We understand that parents may have developed financial/legal arrangements regarding responsibility for medical care. We request that those arrangements be coordinated between the parents. Both parents are responsible for any financial balance although we will normally communicate with the Guarantor listed on the account.

Mother / Guardian Last Name _____ First Name _____

Address _____ City, ZIP _____

DOB _____ SSN _____ Employer _____ E-mail _____

Please check preferred contact phone ☐ Home _____ ☐ Work _____ ☐ Cell _____

Father / Guardian Last Name _____ First Name _____

Address (if different from above) _____ City, ZIP _____

DOB _____ SSN _____ Employer _____ E-mail _____

Please check preferred contact phone ☐ Home _____ ☐ Work _____ ☐ Cell _____

Who is the primary caregiver of the patient? ☐ Both ☐ Mother ☐ Father ☐ Other (explain) _____

If applicable, who has custody? ☐ Both ☐ Mother ☐ Father ☐ Other (Please provide legal document for any alternative custody arrangements)

INSURANCE INFORMATION

Primary insurance _____ Secondary insurance _____

NO-SHOW POLICY: EFFECTIVE AUGUST 1, 2009

- The first **two** no-shows or last minute cancelled appointments will result in a written notification with a $50.00 charge.
- The **third** no-show or last minute cancellation will result in dismissal from our practice.
- Exceptional, unavoidable circumstances will be taken into consideration by our office staff.

Signature _____ Date _____

PLEASE COMPLETE OTHER SIDE

FINANCIAL POLICY

I hereby authorize payment directly to **Gunnison Valley Family Physicians** for all insurance benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges, whether or not paid by insurance,** and for all services rendered on my behalf or my dependents.

Co-pays are due at the time of service. You will receive a bill from our office. We will expect prompt payment from you. If we do not receive payment from you for three consecutive billings, we will turn your account over to a collection agency. If you need to make arrangements for payment, you **must** discuss this with the business office.

I authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. It is our policy to verify patient identity, address and insurance coverage at the time of patient registration/check-in.

I consent to the performance of an examination and treatment which may be deemed necessary in the opinion of the attending physician.

I certify that I have read and understand the above and agree that I am financially responsible for all charges whether or not paid by insurance. I also understand that if my account becomes past due and is turned over for collection, I will also be responsible for any collection fees required to secure this obligation.

_____

Signature of Patient or Responsible Party

Date_____

NOTICE OF PRIVACY PRACTICES / ACKNOWLEDGMENT OF RECEIPT

I have received the Gunnison Valley Family Physicians notice of privacy practices and understand that I am strongly encouraged to read the entire document carefully.

_____

Signature **Date**

Print Patient Name _____