***Family Medical Clinic of Chubbuck*** *January 1, 2021*

**Patient Information Section** **MUST COMPLETE ALL SECTIONS**

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|---|---|---|---|
| Last Name: First Name: M.I.: Preferred Name: | | | Previous Name: (if applicable) |
| Mailing Address: | | City/State/Zip: | |
| Home Phone: | Cell Phone: | | Social Security #: |
| Marital Status: | Date of Birth: | Sex: Male ☐ Female ☐ | **Is today's visit for an Auto Accident or Workers Compensation?** |
| Email address: | | May we leave a voice mail regarding your medical care, test results, & billing? Yes ☐ No ☐ | |
| Primary Physician: | | Other Physicians Caring for You/Physician who Referred You: | |
| Employer Name: Phone: | | Employer Complete Address: | |
| Emergency Contact: | Phone: | | Relationship to Patient: |
| Name of Spouse or Significant Other: | | Employer of Spouse or Significant Other: | |
| Date of Birth: | Social Security #: | | Phone: |
| Address of Spouse or Significant Other: | | City/State/Zip: | |
| Name of Guarantor/Person/Parent responsible for payment of services: | | | |
| Date of Birth: | Social Security #: | | Phone: |
| Address of Person Responsible: | | City/State/Zip: | |
| Employer of Person Responsible: | | Relationship to Patient: | |

| **Primary Medical Insurance** | **Secondary Medical Insurance** |
|---|---|
| Ins. Co. Name: | Ins. Co. Name: |
| **Policy Holder Name:** | **Policy Holder Name:** |
| Subscriber ID Number: Group #: | Subscriber ID Number: Group #: |
| **Policy Holder's Date of Birth: Policy Holder's Address:** | **Policy Holder's Date of Birth: Policy Holder's Address:** |
| Policy Holder's Social Security #: | Policy Holder's Social Security #: |
| Patient Relationship to Policy Holder: | Patient Relationship to Policy Holder: |
| **Employer Name:** | **Employer Name:** |

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|---|---|---|---|---|
| Race (please check one): | American Indian or Alaska Native ☐ | Asian ☐ | Black or African American ☐ | |
| Hispanic ☐ | Native Hawaiian or Pacific Islander ☐ | White ☐ | Other ☐ | Decline ☐ |
| Ethnicity (please select one): | Hispanic or Latino ☐ | Not Hispanic or Latino ☐ | Decline ☐ | |
| English ☐ | Spanish ☐ | Sign Language ☐ | Other | |

**Preferred Pharmacy Name, Location & Phone:**

I have read and agree to Family Medical Clinic of Chubbuck's (FMCC) payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby authorize FMCC to furnish insured's insurance company all information (including HIV, sexually transmitted diseases, drug/alcohol abuse, mental illness, or psychiatric treatment) which may be requested concerning my illness or injury. I also authorize the release of information regarding work related injuries to my employer. I hereby assign to FMCC all money to which I am entitled for medical expenses related to the services performed from time to time by FMCC, but not to exceed my indebtedness to FMCC. Any money received from such insurance company over and above such indebtedness will be refunded to me when my bill is paid in full. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside billing service. If my account is sent to an outside billing service there will be a setup fee up to $30.00 and finance charge(s) (18% APR). Note: Medicare patients will *not* be charged the setup fee or finance charge(s).

MEDICARE BENEFICIARIES: As a Medicare patient, I understand that interest will not be imposed on any outstanding balance. I request that payment of authorized Medicare benefits be made to FMCC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

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| **Signature of Responsible Party:** | | Date: |