88 Norwich New London Tpke
Suite 1
Uncasville, Ct 06382

Phone: 860-848-4180
Fax: 860-848-3471

Patient Name: ____DOB:_____________________

Address:____
Street City/State Zip Code

Mailing Address:____
Street City/State Zip Code

Home Phone:_________________________Cell:______________________Work:_______________

Sex: Male/Female Marital Status: S M D W Email:__________________________________

Employer:____
Name Address Phone

Health Care Proxy: Yes/No ____
If yes: Name Relationship Phone

Primary Care Giver at Home: Yes/ No ____
If yes: Name Relationship Phone

Do you have an Advance Directive: Yes/No If yes where _____________________________________

Next of Kin: ____
Name Address Phone Relationship

Person to Notify In Case of Emergency: ____
Name Address

____
Phone Relationship

Person Responsible for Bill if Patient is a Minor:

Guarantor Name:______________________________Address:_______________________________

Phone:_______________SSN:______________________Relationship to patient:________________

Employer:____
Name Address Phone

Health Insurance Information—*Please provide the office with a current copy of insurance card(s)*

Primary Ins:_______________________ID#________________________Group #_______________

Policy Holder:____
Name Address Phone

____
DOB SSN Employer Relationship to Patient

Secondary Ins:_______________________ID#_______________________Group #_______________

Policy Holder:____
Name Address Phone

____
DOB SSN Employer Relationship to Patient

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Patient Consent and Authorization

Acknowledgement of Receipt of Notice of Privacy Practices
Acknowledgement of Receipt of No Show Policy

I hereby authorize Health 180° personnel and contracted staff to perform any and all tests or procedures relative to my care, injury/illness and/or physical examination as deemed necessary and advisable by the provider and/or employer.

I hereby give permission to my third party payer (Insurance carrier, PPO, HMO, employer) to directly pay Health 180° for services rendered to me. I understand I am responsible for any applicable balance remaining after my insurance has paid and I am to pay the difference within 30 days of notification by Health 180° or my insurance company.

I have been made aware that if the physician does not participate with my health insurance plan I will be responsible for any applicable charges.

I understand and accept that I must pay for any charges which I am billed by Health 180°. I understand that if these medical bills are not paid on time, they may be turned over to a collection agency. If this happens, I understand that I will have to pay, and I agree to pay reasonable collection and attorney fees in addition to lawful interest and cost.

This office participates with an electronic medical record.

This authorization will remain in effect until revoked in by me in writing except to the extent that the practice already made disclosures in reliance upon my prior consent.

I hereby acknowledge I have received a copy of the Notice of Privacy Practices. I understand if I have any further questions or complaints I may contact: **Health 180°'s Office Manager: Sandra at 860-848-4180.**

I also understand that I am entitled to receive updates, upon request, if the Notice of Privacy Practices is amended or changed in a material way.

I hereby acknowledge I have received a copy of the No Show Policy and understand my responsibilities in regards to this policy.

My signature below indicates that I have read and understand each of the paragraphs above.

____________________ ____

Date Patient Signature or Legally Authorized Representative*

*If Legally Authorized Representative: Relationship to Patient: ____

____________________ ____

Date Staff Signature