WELCH FAMILY MEDICINE

PERSONAL/MEDICAL HISTORY FORM

ALL INFORMATION IS CONFIDENTIAL, EXCEPT AS REQUIRED BY LAW

DATE OF BIRTH: _____ GENDER: M F SOCIAL SECURITY # _____

LAST NAME: _____ FIRST NAME: _____ MI: _____

PARENT/GUARDIAN NAME (IF MINOR): _____

PATIENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL: _____ WORK: _____

EMPLOYER NAME: _____ OCCUPATION: _____

SPOUSE NAME:_____ SPOUSE PHONE: _____

SPOUSE HAS ACCESS TO THE FOLLOWING: (CIRCLE ALL THE APPLY)

1. MEDICAL RECORDS 2. SCHEDULE 3. BALANCE/PAYMENT INFORMATION 4. INSURANCE INFO

EMERGENCY CONTACT NAME: _____ PHONE: _____

RELATIONSHIP TO PATIENT:_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:_____

GROUP #: _____ POLICY #: _____

POLICYHOLDER NAME: _____ DATE OF BIRTH: _____

POLICYHOLDER GENDER: M F RELATIONSHIP TO INSURED: _____

POLICYHOLDER EMPLOYER: _____

SECONDARY INSURANCE COMPANY: _____

GROUP #: _____ POLICY #: _____

POLICYHOLDER NAME: _____ DATE OF BIRTH: _____

POLICYHOLDER GENDER: M F RELATIONSHIP TO INSURED: _____

POLICYHOLDER EMPLOYER: _____

WELCH FAMILY MEDICINE

3269 HWY 90 EAST BONIFAY FL 32425

PATIENT NAME: _____ BIRTH DATE: _____

OUR FINANCIAL POLICY:

We are dedicated to providing you with the best possible care & service, and regard you understanding of our financial policies as an essential element of your care & treatment.

Full payment is due at the time of service unless other arrangements have been made in advance.

YOUR INSURANCE

We have made prior arrangements with many Insurers & other health plans. We will bill those plans with which we have an agreement & will collect any required co-payment at the time of service. Your co-payment must be collected at the time of service according to your agreement with your insurance carrier. In the event your health plan determines a service to be "not covered", you will be responsible for payment of that service upon receipt of a statement or an explanation of benefits from your insurance carrier.

PATIENTS WHO ARE MINORS

The adult accompanying patients who is/are children are responsible for payment of all services rendered on that date of service, unless prior arrangements have been made.

OTHER FINANCIAL SERVICES

In many cases the physician orders an x ray or lab test. In the event that these tests are sent out to be interpreted by a specialist, you will receive a separate bill from that facility or specialists.

I have read the above financial policy & I agree to pay all bills on the date of service or as otherwise agreed.

SIGNATURE OF RESPONSIBLE PARTY: _____ **DATE:** _____

WELCH FAMILY MEDICINE

PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED & DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

Your confidential healthcare information may be released to the other healthcare professionals within the office/hospital for the purpose of providing you with quality healthcare.

Your confidential health care information may be released to your insurance provider for the purpose of the office receiving payment for providing you with needed health care services.

Your confidential health care information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime and/or domestic violence.

Your confidential health care information may be released to other healthcare providers in the event you need emergency care.

Your confidential health care information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).

Your confidential healthcare information may NOT be released for any other purpose than that which is identified in this notice.

Your confidential health care information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time. You may be contacted by the office to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

You have the right to restrict the use of your confidential healthcare information. However, the office may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.

You have the right to receive confidential communication about your health status.

You have the right to review & photocopy any/all portions of your healthcare information, a fee of $1 per page will be charged.

You have the right to make changes to your healthcare information.

You have the right to know who has accessed your confidential healthcare information & for what purpose.

You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.

The office is required by law to protect the privacy of its patients. It will keep confidential any/all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information.

This office will abide by the terms of this notice. The office reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.

You have the right to complain the office/hospital if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please notify us as soon as possible. All complaints will be investigated. No personal issue will be raised for filing a complaint. For further information about this Privacy Notice, please contact Leo Welch MD

PATIENT SIGNATURE: _____ DATE: _____