HARDER family practice P.A.

PATIENT INTAKE FORM

PATIENT INFORMATION

Legal Name: _____ _____ _____ Date Of Birth: _____/_____/_____
Last First MI

Birth Sex: M___ F____ Social Security #: _____ -_____-_____ Marital Status: S ____ M ____ D ____ W ____ Other ____

Address _____City _____ State _____ Zip Code _____

Preferred Phone Number: (____)_____Email Address _____

Preferred Contact and Reminder Method (check one): Phone _____ Mail _____ Text _____

Race: White ☐ Hispanic ☐ African American ☐ Other ☐ Declined ☐

Ethnicity: Not Hispanic or Latino ☐ African American ☐ Other ☐ Declined ☐

Preferred Language: English ☐ Spanish ☐ Other ☐

Spouse's Name _____ Spouse's Date of Birth _____ Spouse's Social Security # _____

PRIMARY AND SECONDARY INSURANCE INFORMATION

PRIMARY Insurance Company: _____ Policy Holder ID: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder: Date of Birth: _____ Social Security #: _____ Phone Number: _____

SECONDARY Insurance Company: _____ Policy Holder ID: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder: Date of Birth: _____ Social Security #: _____ Phone Number: _____

RESPONSIBLE PARTY INFORMATION

Complete this section if you would like billing information to be sent to someone **OTHER THAN THE PATIENT.**

Name _____ Relationship to Patient _____ SS#_____ DOB _____

Address: _____ _____ _____ _____
Street City State Zip Code

Preferred Phone Number _____ Email: _____

CONSENT TO CONTACT

I give Harder Family Practice, PA permission to speak to the following person/person's regarding any pertinent medical information.

Name: _____ Relationship to patient: _____Phone Number: (____) _____

Name: _____ Relationship to patient: _____ Phone Number: (____) _____

Name: _____ Relationship to patient: _____ Phone Number: (____) _____

Name: _____ Relationship to patient: _____ Phone Number: (____) _____

_____ _____

Signature of Patient or Parent/Guardian **Date**

FINANCIAL POLICY

I understand that my signature requests that payment be made to the provider and authorizes release of medical information necessary to pay the claim. A photocopy of the authorization and assignment shall be considered as valid as the original. If item of the CMS-1500 claim form is completed, my signature authorizes release of the information to the insurer or agency shown above in Medicare/Other Insurance Company assigned cases. Co-Pay must be paid at the time of service. Payment is due in full within 30 days of the first statement. Patients who fail to pay the account balance within 60 days will become inactive and unable to schedule appointments. Patients who fail to pay within 90 days of the first statement will be sent to collections and a 35% fee will be added.

Effective January 1st, 2023 any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice prior to the scheduled appointment will be considered a No Show and will be charged a $25.00 fee. This fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

I have read and understand the Financial Policy of Harder Family Practice.

_____ _____

Patient Printed Name **Patient Date of Birth**

_____ _____

Patient / Guarantor Signature **Date**