



Date: _____

HILLSIDEHEALTH

PATIENT INFORMATION

| | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|--------------------|------|---------------------|------------------|
| Patient Last Name | | Patient First Name | | Patient Middle Name | |
| Date of Birth | Social Security # | Cell Phone | | Home Phone | |
| Address | | | City | State | Zip |
| Occupation | | Employer | | Business Phone | |
| Employer Address | | | City | State | Zip |
| Driver License # | | Email Address | | | |
| Ethnicity <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Multiracial <input type="checkbox"/> Other | | | | | |
| Emergency Contact Information (Full Name/Relationship to the Patient) | | | | | Phone (REQUIRED) |

What Influenced Your Decision to Come to Our Practice?

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|------------------------------------------------|------------------------------------------------|---------------------------------------|---------------------------------------------|------------------------------------------------------------|-------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Newspaper/magazine ad | <input type="checkbox"/> Clinic website | <input type="checkbox"/> Mailer | <input type="checkbox"/> Insurance plan | <input type="checkbox"/> Friend/family | <input type="checkbox"/> Yellow page book | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Radio or TV ad | <input type="checkbox"/> Facebook/social media | <input type="checkbox"/> Seminar/talk | <input type="checkbox"/> Physician referral | <input type="checkbox"/> Hospital website or referral line | <input type="checkbox"/> Online search | _____ |

INSURANCE INFORMATION (MUST BE FILLED OUT COMPLETELY FOR VERIFICATION PURPOSES)

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|---------------------------|---------|---------------|-------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------------------|
| Primary Insurance Company | | Co-Pay Amount | Policyholder Name | Policyholder DOB | Patient Relationship to Insured Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____ |
| Insurance Company Address | | | | Effective Date | Phone |
| Policy # | Group # | | Group Name | | |
| 2nd Insurance Company | | Co-Pay Amount | Policyholder Name | Policyholder DOB | Patient Relationship to Insured Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____ |
| Insurance Company Address | | | | Effective Date | Phone |
| Policy # | Group # | | Group Name | | |

The Health Insurance Portability Accountability Act (HIPAA) of 1996 was created with the sole purpose and goal of protecting patients' medical records and financial information. Please authorize below who you would like Hillside Health to release your medical and financial information to. This will allow us to better protect your private information. Please be specific when designating your choices.

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|------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>I authorize the staff of Hillside Health to release any FINANCIAL INFORMATION to the following people:</p> <p>_____</p> <p>_____</p> <p>_____</p> | <p>I authorize the staff of Hillside Health to release any MEDICAL INFORMATION to the following people:</p> <p>_____</p> <p>_____</p> <p>_____</p> | <p>I authorize the staff of Hillside Health to leave laboratory or radiology tests results on my voicemail at the following telephone numbers:</p> <p>HOME: _____</p> <p>CELL: _____</p> <p>OTHER: _____</p> |
|------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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|-------------------------------|---------------------------|
| Patient Name: Last, First, MI | Date of Birth: mm/dd/yyyy |
|-------------------------------|---------------------------|

I make the following consents, understandings, and agreements on my own behalf. In partial consideration of health care services to be provided by the Hillside Health (HH) and its affiliates.

CONSENT FOR SERVICES: I hereby give consent to the Facility, its Contractors, Physicians, and Employees to provide health care services to me as the Patient and to administer physician orders for my benefit for this visit and any subsequent visits. I understand this consent may be revoked in writing at any time. I understand that there is a risk involved in such health care services, and I accept such risk in the hope of obtaining beneficial results from such services. No promises of any particular outcome or successful result have been made. I understand and accept that there is some uncertainty involved in the health care services for which this consent is given.

ASSIGNMENT OF BENEFITS: Any and all benefits from insurance companies and other third-party payers that are payable to me, the Patient for health care services and related payments for services rendered or provided to the Patient are hereby transferred and assigned to the HH for the exclusive purpose of paying for charges associated with the health care services provided to me. I understand and intend that all insurance companies and other third-party payers will pay benefits directly to the HH for services rendered to me and that the HH is authorized to bill in connection with health care services provided.

RELEASE OF INFORMATION: The HH is required by law to make and keep records of the Patient's medical treatment. The HH safeguards those records and it uses and discloses such records and information they contain only in accordance with the State and Federal privacy laws. Such uses and disclosures are described in detail in the Hillside Health's Notice of Privacy Practices, which may be amended from time to time. I understand that I may ask to see a copy of the current notice at any time.

MEDICARE/MEDICAID/TRICARE PATIENT'S CERTIFICATION: I certify that the information given by me in applying for payment under the titles XVIII and XIX of the Social Security Act or in connection with any other government program is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, other intermediaries or carriers, or the State any information needed to process a claim for this or any related service. I request that payment of authorized charges be made in my behalf directly to the Facility for its charges and for any charges of physicians or other providers for whom the Facility is authorized to bill in connection with its service.

FINANCIAL RESPONSIBILITY: I, the undersigned, jointly and severally agree to pay for all the health care services rendered to me, the Patient including but not limited to any amounts not paid by any insurance company or other third-party payor (excluding contract discounts). I remain responsible for all copayments, deductibles, co-insurance, and / or non-covered services regardless of amount paid by insurance or third-party payor. I understand and agree that any amounts not paid within 30 days of the date of the bill or statement for payment shall accrue interest at the rate of 1.5 % per month (18% per year) on the unpaid balance. In the event that any unpaid balance is placed with a collection agency or attorney for collection, I jointly and severally agree to pay all costs of collections and reasonable attorney's fees in connection with the collection process. As a courtesy to our personal pay patients, a discount is extended for specified services. The largest discount is available when services are paid in full on the date of service. Please ask about any discounts that may be available.

I sign this document as the Patient to execute this document and to accept and agree to its terms. I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction, and I indicate my understanding by signing above. I understand that I am entitled to request and obtain a copy of this document, as well as a copy of my billing rights according to the Fair Credit and Billing act. This document will remain in effect unless revoked in writing.

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| SIGNATURE: _____ | DATE: _____ |
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