Jonathan Sack, MD It's Your Health!

PATIENT INFORMATION

Last Name:_____First Name: _____Middle:_____

Social Security Number: _____

Date of Birth: _____

Address: _____

City: _____ State:_____Zip code:_____

(Circle One)
Sex: Male Female
Race: White Black Asian Indian Hawaiian
Ethnicity: Hispanic Non-Hispanic
Language Preference: English Spanish Chinese German Other:_____

Primary Telephone: _____Alternate Telephone: _____

E-Mail: _____

Primary Insurance Subscriber: (circle one): self spouse child other
****If above is not "self" please provide subscribers Social Security Number and date of birth for the front desk. ****

SSN: ____-____-____ **Date of Birth**: _____/_____/_____

Marital Status (circle one): Single Married Divorced Separated Widowed

Employer: _____Phone: _____

Emergency Contact Name: _____Phone: _____

Assignment of Benefits, Release of Information, & HIPAA Notice of Privacy

I authorize payment of medical/surgical benefits to the above named provider for professional services rendered. I also authorize the release of any medical information necessary to process this claim, to process any laboratory or pathology specimens, to communicate with other physicians and family members/guardians as a part of my care, and to use any photographs for teaching purposes. I am aware that a copy of the *Privacy Practices* is available in the reception area. I understand that my health information is protected and I may request in writing a current copy of Island Family Medicine's *Notice of Privacy Practices.*

Patient / Representative Signature: _____Date: _____

Acknowledgement Note

Your insurance policy is a contract between you and your insurance company so we cannot guarantee payment on claims. Please remember that insurance is considered a method of reimbursing the physician for fees provided to the patient and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charges. It is your responsibility to pay any deductible amount, co-insurance, copays, and all other balances not paid by your insurance company. It is customary to pay for all services when rendered. This office will file for your insurance benefits on plans in which we participate. We accept assignment based on Medicare's fee schedule. Necessary information will be supplied to you to enable you to file your own claim on other plans. You are responsible to this office for all fees not paid within 45 days, regardless of insurance coverage, along with collection expenses and reasonable attorney / collection fees. I understand the above statements.

Patient / Representative Signature:_____**Date**: _____