Sherwood Family Medicine

Patient Information

Completion of this information in its entirety is required at time of visit

NAME_____Social Security #_____-____-_____DOB_____

Last First Middle

Mailing Address_____ _____ _____ _____

Street City State Zip

Primary Phone (_____)_____-_____ Secondary Phone (____) _____-_____ Work Phone (____) _____-_____

Employer_____Occupation_____

E-mail Address_____

Marital Status (check one): Single___ Married ___ Divorced___ Separated____ Domestic Partner ____ Widow___

Race_____ Ethnicity: Hispanic___ Non-Hispanic ___ Refused___ Preferred Language_____

In Case of Emergency:

Family Member _____Phone (___) ____-_____
Relationship to patient_____
Other Person to contact _____Phone(___) _____-_____
Relationship to patient_____

How do you intend to pay? **Cash Policy** **Insurance**

Primary Insurance Co._____ID#_____
Name of Insured_____DOB of Insured_____Group#_____
Insured's Social Security #_____
Secondary Insurance Co._____ID#_____
Name of Insured_____DOB of Insured_____Group#_____
Insured's Social Security #_____

If someone other than the patient is responsible for payment (or is the primary insured), complete the following:

Name of the responsible party_____SSN# _____
Address_____DOB_____
Relationship to patient_____ Home Phone (___) _____-_____
Employer_____Address_____Work Phone (___)____-_____

Please Read and Sign Below

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections for any amount owed on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment.

As a courtesy to all our patients, we require a 24 hours notice for cancellations and reschedules. For cancellations/reschedules/no-shows without adequate notice, there will be a charge of $50.00 that is not billable to insurance. We appreciate your courtesy in this matter.

PRESCIPTIONS REFILLS: We require 72 hour notice for all prescription refills. Please contact your pharmacy directly to initiate refill.

We expect each staff member to treat each patient with courtesy and respect. We expect the same from our patients. We are here to assist you in your needs. We do not tolerate inappropriate behavior or language and engaging in such is cause for termination of care.

Signature_____Date_____
(Responsible party signature if patient is under 16 years of age)

Sherwood Family Medicine

Consent for Treatment (General)

Date: _____

Patient Name: _____

Patient Date of Birth: _____

I authorize treatment deemed medically necessary on the above named patient. I understand that if there are specific procedures I am scheduled for that I will sign a specific consent for each procedure. This consent is for general treatment needed when scheduled for care at Sherwood Family Medicine.

Patient Signature: _____

Signature of Patient's Representative:_____

(If patient is under 15)

Relationship of Representative:_____

Sherwood Family Medicine

Financial Agreement

Date: _____

Patient Name: _____

Patient Date of Birth: _____

I authorize Sherwood Family Medicine to provide to my insurance companies all information necessary to process insurance claims and assign Sherwood Family Medicine all of the insurance benefits due to me the full extent of my financial obligation.

I understand that I am ultimately responsible for my balance with Sherwood Family Medicine if my insurance does not pay or for whatever portion is deemed patient responsibility.

I understand that when I receive a statement from Sherwood Family Medicine this is my responsibility and I am required to pay in full all balance due or to call the Billing Manager to make payment arrangements.

_____

Patient or Patient's Representative Signature

(If patient is under 16)

_____

Date

Others Involved in Healthcare

As stated in our Notice of Privacy Practices, we may disclose your protected health information that is directly related to that person's involvement in your health care to a member of your family, a relative, a close friend or any other person that you choose.

We request that you designate the individuals with whom we may discuss your protected health information.

The permission granted below may be rescinded and/or modified at any time. Such a change must be made in writing to :

Sherwood Family Medicine
20015 SW Pacific Hwy., Ste. 300
Sherwood, OR 97140

I,_____, give Sherwood Family Medicine permission to discuss my protected health information with the following person(s):

NAME	Phone Number	Relation
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Patient or Patient Representative Signature (If patient is under 15) Date

_____ _____
Witness Signature Date

Sherwood Family Medicine

Acknowledgment of Notice

These regulations require us to make a good faith effort to obtain your written acknowledgment of receipt of the notice of privacy practices, so we request that you read and sign the following:

I acknowledge receipt of Sherwood Family Medicine's Notice of Privacy Practices.

_____ _____

Patient's Signature Date

(If patient is under 15, then patient representative signs)

_____

Patient's Name (please print)