WOODCREEK HEALTHCARE

ACCOUNT # _____ INITIALS _____

PATIENT INFORMATION

Name _____ (First / Middle / Last)

Address _____ (Street / P.O. Box)

_____ (City / State / Zip)

Home Phone _____ Cell Phone _____

Work Phone _____

Birthdate _____ (mm/dd/yyyy) Age _____ SSN _____

Marital Status ❑ Single ❑ Married ❑ Other

Gender ❑ Male ❑ Female

Occupation _____

Employer _____

Primary Provider _____

Referring Provider _____

RESPONSIBLE PARTY (CUSTODIAL PARENT/ LEGAL GUARDIAN/ OTHER LEGALLY AUTHORIZED REPRESENTATIVE)

Name _____ (First / MI / Last)

Address _____ (Street / P.O. Box)

_____ (City / State / Zip)

Home Phone _____ Cell Phone _____

Work Phone _____

Birthdate _____ (mm/dd/yyyy) SSN _____

Gender ❑ Male ❑ Female

Patient Relationship to Responsible Party _____

Employer _____

Email _____

PRIMARY INSURANCE CARRIER INFORMATION

Name _____ (First / MI / Last)

Address _____ (Street / P.O. Box)

_____ (City / State / Zip)

Home Phone _____ Cell Phone _____

Work Phone _____

Birthdate _____ (mm/dd/yyyy) SSN _____

Gender ❑ Male ❑ Female

Patient Relationship to Insured Party _____

Employer _____

Insurance Company _____

Insured ID # _____

Policy/Group _____

SECONDARY INSURANCE CARRIER INFORMATION

Name _____ (First / MI / Last)

Address _____ (Street / P.O. Box)

_____ (City / State / Zip)

Home Phone _____ Cell Phone _____

Work Phone _____

Birthdate _____ (mm/dd/yyyy) SSN _____

Gender ❑ Male ❑ Female

Patient Relationship to Insured Party _____

Employer _____

Insurance Company _____

Insured ID # _____

Policy/Group _____

EMERGENCY CONTACT INFORMATION (Please include other parent when applicable as well as someone who does not live in your household)

Contact #1 _____ (First / Last)

Home Phone _____ Cell Phone _____

Work Phone _____

Patient Relationship to Contact _____

Contact #2 _____ (First / Last)

Home Phone _____ Cell Phone _____

Work Phone _____

Patient Relationship to Contact _____

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS, NOTICE OF PATIENT PRIVACY PRACTICES, & EMAIL

I authorize my insurance benefits to be paid directly to Woodcreek Healthcare for services rendered. I also authorize Woodcreek Healthcare to release any information requested by the insurance company with regards to payment of benefits. I acknowledge financial responsibility for all charges relating to my care at Woodcreek Healthcare that are not covered by insurance. I understand that I may be billed directly from other lab and/or x-ray facilities for charges incurred for diagnostic services. I consent to treatment of the patient above as deemed necessary and appropriate by the attending provider.

Financial Policy: All balances are due and payable within thirty (30) days of the initial statement date unless prior arrangements have been made. After 30 days a $7.50 rebilling fee will be added to your account every twenty-five (25) days until your balance is paid. The person requesting treatment is responsible for all services rendered. However, if the patient is a minor, the custodial parent or guardian is responsible for all services rendered.

Notice of Patient Privacy Practices: Woodcreek Healthcare's Notice of Patient Privacy Practices describes how medical information about you may be used and disclosed, and how you can get access to this information. Woodcreek Healthcare reserves the right to change its practices regarding the protected health information it maintains. If Woodcreek Healthcare makes changes, they will update this Notice. By my signature below, I acknowledge that I may receive the most recent copy of this Notice by visiting www.woodcreekhealthcare.com, requesting the Notice at any of Woodcreek Healthcare's locations, or viewing the posted Notice in the reception area of any of Woodcreek Healthcare's clinics.

Email: By providing your email address above, you are entitled to receive Woodcreek Healthcare's eUpdates, eStatements, and eAppointment Confirmations. E-Updates may contain information regarding programs or services our clinics provide as well as general information for your family. Your email address will not be sold or provided to third parties. Your email address may be removed from our list at any time as noted at the bottom of each email.

_____ Signature of Responsible Party

_____ Relationship to Patient

_____ Date