Pisgah Family Health, P.A.

Please PRINT

➢ **Patient Last Name** _____ First _____ MI ____
Address _____
City _____ ST _____ Zip _____-_____
Phone (Home) _____ Date of Birth _____
Marital Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced
SSN _____-_____-_____ Driver's License No _____ ST _____
Email _____ Cell Phone _____

Employer Name _____
Phone (Work) _____ Occupation _____

➢ **Person Responsible for the Bill:** ☐ Self* ☐ Spouse ☐ Parent ☐ Other

*If self, you do not need to complete this area again, please sign state
Last Name _____ First _____ MI ____
Addres_____
City _____ ST _____ Zip _____-_____
Phone (Home): _____ Gender: ☐ M ☐ F
SSN: _____ Date of Birth _____
Employer Name_____ Phone (Work) _____

*I understand that I am financially responsible for my charges with Dr Curran.
Signature _____

➢ **Patient Insurance:** Please give insurance card(s) to receptionist when forms are complete

☐ Medicare ☐ Medicaid ☐ Cash pay ☐ Insurance Co-pay $ _____

➢ **How did you learn of Pisgah Family Health, PA?**

☐ Yellow Pages ☐ Yellow Book ☐ MD referral _____

☐ Patient or family member ☐ ER/ProMed ☐ Employee referral ☐ Insurance Co

☐ First Impressions ☐ Welcome Newcomer ☐ Direct Mailing ☐ Other _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name or Legal Guardian: _____

Signature: _____ Date: _____