Unity HEALTH

North Cabot Family Medicine

PATIENT INFORMATION

Date: _____

Pharmacy: _____

Patient Name: _____ Birth Date: _____
(last) (first) (MI)

Patient SSN: _____ Email Address: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Patient Employer: _____ Occupation: _____

Employer Address: _____

Sex: *Male*_____ *Female* _____ Marital Status: *Single* _____ *Married* _____ *Divorced* _____ *Widowed* _____

Race: (Please circle one): *Caucasian (White) Black/African American Asian Native American Hispanic Asian Native American Hispanic Asian Pacific American Pacific Islander Native Hawaiian Subcontinent Asian American American Indian or Alaskan Native More than one Race Other Race Not Reported*

Ethnicity (Please Circle One): *Latino/Hispanic Other Not Reported*

Spouse Name: _____ Birth Date: _____

Spouse Employer: _____ Spouse SSN: _____

Employer Address: _____ Work Phone: _____

_____ **Responsible Party or if under 18 Years of Age** _____

Father/Guarantor: _____ Mother/Guardian: _____

Employer: _____ Employer: _____

Address: _____ Address: _____

Work Phone: _____ Work Phone: _____

Home Address (if different from patient): _____

Home Address (if different from patient): _____

Father/Guardian SSN: _____ Mother/Guardian SSN: _____

Birth Date: _____ Birth Date: _____

Unity HEALTH

North Cabot Family Medicine
A Division of Unity Health/White County Medical Center
ADDENDUM: PATIENT PRIVACY

Patient's Name: _____

Date of Birth: _____

Social Security Number: _____

In an effort to comply with current HIPAA (Health Insurance Portability Accountability Act) regulations, we need you to complete the following information. Please list any person other than your doctor with whom we may discuss your private health information or financial matters.

_____ Phone _____ Relationship _____

_____ Phone _____ Relationship _____

_____ Phone _____ Relationship _____

In addition, please provide the name(s) of anyone you authorize to have access to your patient portal.

_____ Phone _____ Relationship _____

_____ Phone _____ Relationship _____

_____ Phone _____ Relationship _____

In the event that we are unable to reach you personally, do you give permission to a staff member of **North Cabot Family Medicine** to leave a message on your answering machine and/or leave a message with someone at your home number concerning your private health information or financial matters?

I understand I can withdraw the above at any time, with written request. I also understand that it is my responsibility to ensure that my family member or significant other do not divulge or use the information in any way without discussing it with me first.

_____ _____

Patient or Legally Authorized Individual Signature Date

_____

Relationship to patient if signed by anyone other than the patient
(parent, legal guardian, personal representative, etc.)

Unity HEALTH

Pt. Name:_____

North Cabot Family Medicine

Consent for Treatment, Assignment of Benefits and Release of Information

I, the undersigned, consent to being treated by the **North Cabot Family Medicine** physicians, nurse practitioners and/or physician assistants, as is necessary or advisable in their judgment. I also consent to the disclosure of my protected health information in an electronic format to Mayo Clinic for purposes of an "e-consult" if necessary in the opinion of my physician, his assistant, and/or designee.

I also authorize payment directly to **North Cabot Family Medicine** for all medical services provided to me. I understand this assignment and authorization is for all benefits that are payable by any insurance company or third party payer on my behalf. I understand that I am financially responsible to **North Cabot Family Medicine** for all charges not paid by my insurance company or any third party payer, including all copayments and deductibles. I agree that **North Cabot Family Medicine** and its assignees and contractors may take all of the following actions regarding amounts owed to the Clinic: (1) contact me by telephone at any telephone number I provide, (2) leave voicemail or answering machine messages for me, (3) send emails or text messages to any account or number I provide, or (4) use pre-recorded voice messages or an automatic dialing device to contact me.

I also authorize **North Cabot Family Medicine** to disclose all or any part of my protected health information to any person or entity which is or may be responsible for any of the Clinic charges for services provided to me. This authorization to disclose information and the assignment of benefits will remain in effect until all charges have been paid that are due to the Clinic. This authorization to disclose protected health information specifically includes the authorization to disclose any information regarding treatment for a substance abuse disorder, which is protected by Federal law (42 CFR Part 2). Any disclosure of information that is protected by 42
CFR Part 2 pursuant to this authorization is only permitted for purposes of payment or healthcare operations and not for purposes of treatment.

I acknowledge, by my signature below, that I have read this document and that I am the patient or the patient's personal representative, as indicated below.

_____ _____/_____/_____

Patient Signature Patient DOB

_____

Printed Name

_____/_____/_____

Date

_____

Personal Representative of Patient

_____

Relationship to Patient

Unity HEALTH

PATIENT NOTICE ACKNOWLEDGMENT

The signature below acknowledges a copy of this Notice was RECEIVED (not necessarily read)

Patient/Printed Name _____ Date _____

Patient/Legal Representative Signature _____ Date of Birth Parent _____

State Capacity, If Legal Representative _____

FOR INTERNAL USE ONLY

Lack of Patient Acknowledgement

Date Reason Staff Signature

North Cabot Family Medicine
MEDICATION MANAGEMENT/ALLERGIES

Patient Name: _____

Date of Birth: _____

Please list all current medications below. Please include dose and how often the medication is taken.

Medication	Dose	How Often?

What pharmacy do you use? _____

Please list allergies or if you are allergic to any mediations:

Allergy	Reaction