Healthy Habits wellness center

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PATIENT INFORMATION

Date: _____ Preferred Pharmacy: _____

Patient Name: _____
(Last) (First) (Middle)

Preferred Name: _____ Maiden Name: _____ Prefix: _____ Suffix: _____

Date of Birth: _____ Sex: ❑ Female ❑ Male Social Security #: _____

Race: ❑ Am Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ White ❑ Nat Hawaiian/Pacific Islander ❑ Declined ❑ Other

Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino ❑ Declined

Preferred Language: ❑ English ❑ Spanish Other: _____

Marital Status: _____ Driver's License: _____ Religion: _____

Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: Home: _____ Work: _____ Cell: _____ Primary: ❑ Home ❑ Work ❑ Cell

Fax: _____ Pager: _____ Email: _____

Preferred Communication Method: ❑ Email/Patient Portal ❑ Mail ❑ Phone-Cell ❑ Phone-Home ❑ Phone-Work

EMPLOYER INFORMATION

Employer: _____ Employment Status: ❑ Full time ❑ Part Time

Occupation: _____ Employer Phone: _____

Employer Address: _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name: _____
(Last) (First) (Middle)

Address: _____

Home Phone: _____ Work Phone: _____ Relationship to Patient: _____

Date of Birth: _____ Sex: ❑ Female ❑ Male Social Security #: _____

PRIMARY INSURANCE

Insurance Company Name: _____ Insurance Phone: _____

Insurance Company Address: _____

Insurance Policy ID: _____ Group Name/Number: _____

Subscriber/Policy Holder Name: _____ Subscriber Date of Birth: _____

Subscriber SSN: _____ Subscriber Address: _____

Relationship to Patient: _____ Effective Date of Coverage: _____ Copay: $_____

SECONDARY INSURANCE (If applicable)

Insurance Company Name: _____ Insurance Phone: _____

Insurance Company Address: _____

Insurance Policy ID: _____ Group Name/Number: _____

Subscriber/Policy Holder Name: _____ Subscriber Date of Birth: _____

Subscriber SSN: _____ Subscriber Address: _____

Relationship to Patient: _____ Effective Date of Coverage: _____ Copay: $_____

EMERGENCY CONTACT

Closest relative/friend not living at same address: _____

Home Phone: _____ Work Phone: _____ Relationship to Patient: _____

AUTHORIZATION FOR ACCOUNT ACCESS

Please list any individuals that you authorize Healthy Habits Wellness Center representatives to speak with regarding questions relating to your bill or statement, including your account information, insurance information, charges and payments.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

AUTHORIZATION AND CONSENT (Please initial each line item and sign and date below)

_____I authorize the providers at Healthy Habits Wellness Center to render treatment deemed necessary in his/her professional opinion. I will make every effort to comply with the recommended course of treatment.

_____I understand that payment is due at the time service is rendered. I understand that copays are due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize the authorization allows Healthy Habits Wellness Center, Inc., to release any information to any of my insurers or physicians. I authorize Healthy Habits Wellness Center access to view my pharmacy benefits when available from my insurance company.

_____I authorize and direct my insurers to pay directly to Healthy Habits Wellness Center, Inc., and/or its physicians any and all benefits up to the amount of my bill pertaining to all charges incurred. I assign to Healthy Habits Wellness Center Inc., including its affiliates, any and all benefits or proceeds, of any type whatsoever, to which I am entitled, with respect to the health care service(s) I receive, including but not limited to, the proceeds of any liability settlement or judgment being paid by or on behalf of a third-party and any benefits due from any third-party insurance policy. I direct that all such benefits be paid directly to Healthy Habits Wellness Center, Inc., and/or its affiliates, including its physicians, and applied to my account(s) until the account(s) is paid in full. I understand that I am personally responsible for any remaining fees. I hereby agree to pay all costs and reasonable fees in the event this account is turned over for collections. I authorize Healthy Habits Wellness Center, Inc., to contact me on any phone number provided by me for the purposes of conducting business with me or contacting me concerning my account. I understand that I am financially responsible to Healthy Habits Wellness Center for all charges not covered, approved or considered necessary by my insurance company. I will pay at the time of service or will establish an agreeable payment arrangement with the Office Manager.

Signature: _____ Date: _____

Signature: _____ Date: _____

Responsible Party Signature (if different than patient)