Owensville PRIMARY CARE

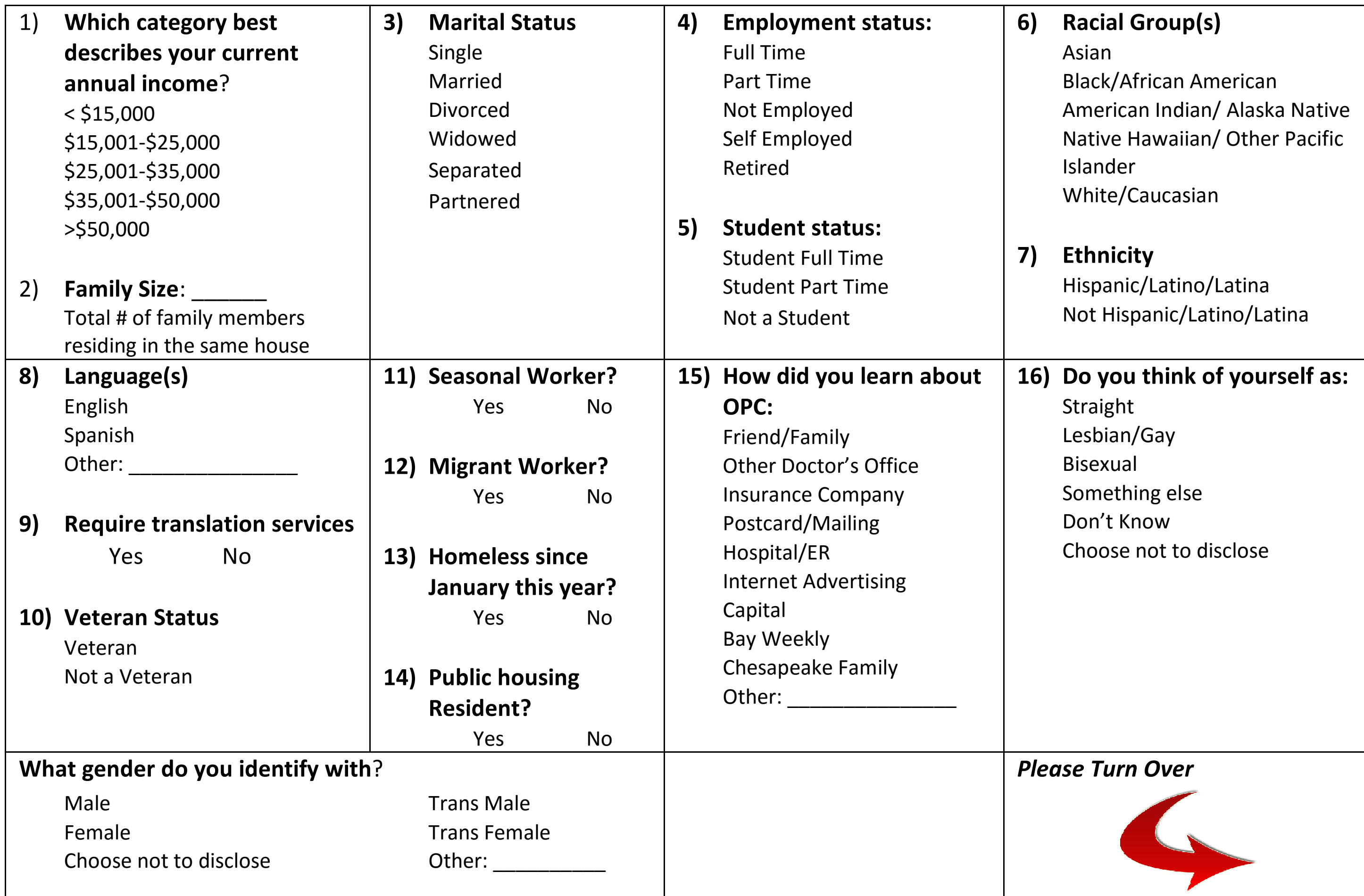
Date:_______________

Legal Name *Last*	*First*	*Middle Initial*	*Maiden Name (if Married)*
Legal Sex: Male Female	**Date of Birth** Month / Day / Year		**Social Security #**

Please be aware that the name & sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. Your answers to the following question will help us reach you quickly & discretely with important information

Home Phone ( )	**Cell Phone** ( )	**Work Phone** ( )	**Best number to use:** ( ) Home ( ) Cell ( ) Work
Local Address	City	State	Zip
Billing Address (if different from above)	City	State	Zip
Email Address			
Responsible Party Name	**Phone Number**	**Relationship to you**	
Responsible Party Address	City	State	Zip
Emergency Contact's Name	**Phone Number**	**Relationship to you**	

This information is for Bureau of Primary Health Care reporting purposes and ensures federal funding to serve our patients. We respect that this is personal and confidential information. Your cooperation in completing this section is appreciated.



1) **Which category best describes your current annual income?**
< $15,000
$15,001-$25,000
$25,001-$35,000
$35,001-$50,000
>$50,000

2) **Family Size**: ______
Total # of family members residing in the same house

3) **Marital Status**
Single
Married
Divorced
Widowed
Separated
Partnered

4) **Employment status:**
Full Time
Part Time
Not Employed
Self Employed
Retired

5) **Student status:**
Student Full Time
Student Part Time
Not a Student

6) **Racial Group(s)**
Asian
Black/African American
American Indian/ Alaska Native
Native Hawaiian/ Other Pacific Islander
White/Caucasian

7) **Ethnicity**
Hispanic/Latino/Latina
Not Hispanic/Latino/Latina

8) **Language(s)**
English
Spanish
Other: _______________

9) **Require translation services**
Yes No

10) **Veteran Status**
Veteran
Not a Veteran

11) **Seasonal Worker?**
Yes No

12) **Migrant Worker?**
Yes No

13) **Homeless since January this year?**
Yes No

14) **Public housing Resident?**
Yes No

15) **How did you learn about OPC:**
Friend/Family
Other Doctor's Office
Insurance Company
Postcard/Mailing
Hospital/ER
Internet Advertising
Capital
Bay Weekly
Chesapeake Family
Other: _______________

16) **Do you think of yourself as:**
Straight
Lesbian/Gay
Bisexual
Something else
Don't Know
Choose not to disclose

What gender do you identify with?
Male
Female
Choose not to disclose
Trans Male
Trans Female
Other: __________

Please Turn Over

Owensville
PRIMARY CARE

Date:_______________

Payment/Insurance Information

PLEASE PROVIDE YOUR INSURANCE CARD AT THE TIME OF REGISTRATION. A list of insurance we accept is available on our website. Our registration staff can also assist you.

________ *(Initial)*

METHOD OF PAYMENT

I understand and acknowledge that payment is due at the time service is rendered. This includes all co-payments and co-insurance responsibilities. Any variation to this policy must be pre-arranged through our Accounting Department, prior to being seen. We accept Cash, Checks, Money Orders, Visa, MasterCard, American Express, and Discover.

________ *(Initial)*

INSURANCE AUTHORIZATION, ASSIGNMENT AND PAYMENT OF SERVICES

I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to Owensville Primary Care for any services furnished me by that party who accepts assignment/clinical provider. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to be released in order to process payment of such services. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for treatment. I also understand that it is my responsibility to be knowledgeable of my insurance benefits and requirements. I understand that based on my health insurance policy, there may be services that the Clinical Provider of OPC may deem necessary that may not be covered by my health insurance, and I shall be held responsible for the payment of such services. I understand and acknowledge that payment is due at the time service is rendered. This includes co-payments, patient responsibility percentage of office visit/procedural charge and any previous back charges. Any variation to this policy must be pre-arranged through our Accounting Department, prior to being seen.

________ *(Initial)*

AUTHORIZATION TO TREAT

Permission is hereby given to the Clinical Providers of Owensville Primary Care, Inc. (OPC), to administer such diagnostic, operative, or treatment procedures to the above named patient that are deemed necessary. This includes accessing information from an online pharmacy database about medications that I may be taking for the purpose of continued treatment.

________ *(Initial)*

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of this provider's *Notice of Privacy Policies*, detailing how my information may be used and disclosed as permitted under federal and state law.

________ *(Initial)*

ADVANCE DIRECTIVE

I acknowledge receipt of "Advance Directives" pamphlet/form. This information was given to me *as* part of my "New Patient" documents. I fully intend to read this pamphlet, and should I decide to choose the use of the advance directives, I will complete the form and will return the signed document back to OPC to maintain with my medical records.

The below signature acknowledges your agreement to the above disclosures:

X ____ **Date:** ___________________________

____ ___________________________________