

<b>Appointment Date:</b>		<b>Appointment Time:</b>		<b>Appointment Doctor:</b>	
<b>Patient Name:</b>			<b>Email Address:</b>		<b>Account No</b>
<b>Patient address, street/city/state/zip:</b>			<b>DOB:</b>		<b>Social security no:</b>
<b>Race:</b> <input type="radio"/> AmericanIndian/AlaskaNative <input type="radio"/> Asian <input type="radio"/> NativeHawaiian/Other Pacific <input type="radio"/> White <input type="radio"/> Black/AfricanAmerican <input type="radio"/> Hispanic <input type="radio"/> Refuse to Report <input type="radio"/> Other Race			<b>Language:</b> <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other		<b>Ethnicity:</b> <input type="radio"/> Hispanic/LatinAmerican <input type="radio"/> NonHispanic/NonLatinAmerican <input type="radio"/> Refuse to Report
<b>Primary contact</b>		<b>Home phone:</b>		<b>Cell Phone:</b>	
<b>Primary Insurance Info:</b>			<b>Subscriber No/ Group No:</b>		
<b>Subscriber:</b>			<b>Subscriber SSN:</b>		<b>DOB:</b>
					<b>Relationship:</b>
<b>Employer:</b>			<b>Emergency Contact Name/Number/Relation:</b>		

**If you wish to give Parental Permission to treat your Minor Children:**

I hereby request and authorize Conifer Medical Center to deliver medical care to my dependent child in the event that I am unable to be reached within a reasonable period of time. All reasonable efforts will be made to contact me prior to treating my child.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Valid until revoked in writing**

**Consent to Share Medical Information:**

I give my consent to share my medical information with the following individuals:

\_\_\_\_\_

I do not wish to share my information with anyone.

**Voice message authorization:** I authorize CMC to leave voice messages at this number:

HOME                       CELL                       WORK

I authorize Conifer Medical Center to release medical information for Billing, Quality Assurance and Utilization Review Purposes. I assign to Conifer Medical Center all Payments for medical services. I verify that all information contained on this form is true and correct to the best of my knowledge and belief.

- Copays for ALL visits are due at time of service; otherwise a service fee of \$15 will apply.
- No Show appointments WILL be charged \$50. You MUST CALL 12 hours in advance if you are unable to keep your appointment!
- ALL collection fees including a 40% charge, reasonable attorney fees, court costs and returned check fees are the responsibility of the account guarantor.
- After Hours Charges: Our insurance contracts allow us to bill after hours charges due to our extended patient hours. It is CMC's policy not to bill our patients for this.

**Verifying your plan coverage and benefits denied is your responsibility.**

**I have read, understand and agree to the above payment policy and CMC's HIPAA policy.**

**Responsible Party Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_