

Conner Family Health Clinic, PLLC

211 W. Matthews Street, Suite 102, Matthews, NC 28105, connerclinic@connerclinic.com, 704.708.4301, 704.708.4389 - Fax

Patient Information		Date:	MR #	
Patient Name		Primary Language:		Race:
Address		<input type="checkbox"/> English		<input type="checkbox"/> African American
City/State/Zip		<input type="checkbox"/> Spanish		<input type="checkbox"/> Asian
		<input type="checkbox"/> French		<input type="checkbox"/> Caucasian
		<input type="checkbox"/> Other:		<input type="checkbox"/> Hispanic
				<input type="checkbox"/> Other:
Home Phone	Work Phone:	Employer/School		
SS#	DOB (Age)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status	
Emergency Contact	Relationship to Patient	Emergency Contact Phone #	Patient Email Address	
Responsible Party	Relationship to Patient	Responsible Party DOB	Responsible Party SS#	
Responsible Party Address		City/State/Zip	Responsible Party Phone #	
Insurance Information				
Primary Insurance	Insured's Employer	Secondary Insurance	Employer	
Insurance ID #	Insurance Group #	Insurance ID #	Insurance Group #	
Insured's Name (if different from patient)		Insured's Name (if different from the patient)		
Address		Address		
City/State/Zip		City/State/Zip		
Insured's DOB	Insured's SS#	Insured's DOB	Insured's SS#	

Financial Responsibility and Assignment of Insurance Benefits:

I guarantee payment to Conner Family Health Clinic of all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits, which would otherwise be payable to me, to Conner Family Health Clinic for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct.

Consent for Healthcare and Release of Medical Information:

I voluntarily consent to healthcare treatment ("Treatment") from the physicians and staff at this clinic. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatments or examinations by my caregivers. I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations. I have read this form and have had the opportunity to ask questions and my questions have been answered.

Signature of Patient or Authorized Person: _____	Date: _____
Insured Party or Financial Guarantor, if different from above: _____	Date: _____

Acknowledgment of Receipt of Privacy Notice:

I have received a copy of the Conner Family Health Clinic Notice of Privacy Practices. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice from the Clinic.

Signature of Patient or Authorized Person: _____	Date: _____
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For Staff Only: Patient refused to sign privacy notice.