Information Required for New Patients

PATIENT INFORMATION:

Name of Patient: ______________________________

Date of Birth: __________/___________/____________ Social Security Number: ______________________

Patient lives in: _____ Private Home _____ Facility Name of Facility:______________________

Address where Patient Resides: ______________________________ Unit #: ______________

______________________________ZIP____________________

Telephone where patient resides: ______________________ Cell: ______________________

Facility Contact Name and #:______________________ Facility Fax #: ______________________

Does Patient Have a Medical Power of Attorney (MPOA) : No________ Yes_______ **(If yes, copy of POA paperwork is required)**

POA or Primary Contact Name:______________________ Phone:______________________

Is Patient on Hospice? No_____ Yes_____ Name of Hospice: ______________________Term Date: ______________

Current/Preferred Pharmacy Name: ______________________ Pharmacy Phone: ______________________

GUARANTOR INFORMATION: (Person responsible for payment if not patient)

Bill To Name: ______________________________

Bill To Address: ______________________________ Unit #: _____________

City: ______________________________ Zip Code: ______________________

Bill To Phone: Primary ______________________ Secondary:______________________

INSURANCE INFORMATION: - Please Fax Copies of Insurance Cards

Medicare ID # (Including Alpha Letter) REQUIRED FOR ALL PATIENTS: ______________________

CASE MANAGER (if applicable): Name: ______________________ Phone: ______________________

PRIMARY Insurance Company: ______________________________
(Enter Information. Do not write see attached)
Address & Tel ______________________________

Policy ID # ______________________________

ADDITIONAL Insurance Company: ______________________________
(Enter Information. Do not write see attached)
Address & Tel ______________________________

Policy ID # ______________________________

Blue Cross/Blue Shield and Health Net - Must Include Group #______________________________

8111 E. Thomas Road Ste 124 * Scottsdale, AZ 85251 * Tel 602-954-0444 * Fax 602-952-7146

ASSIGNMENT OF BENEFITS:

I hereby authorize my insurance company to make direct payments to Geriatric Solutions.

I understand that I am ultimately responsible for my bill.

I am aware that Medicare does not pay for preventative medicine, routine screening tests, or routine physician examinations. I also understand that I will be responsible for the deductible and co-insurance amount.

Insured/Policyholder Signature:____ **Date:** ________________________________

PATIENT PRIVACY:

May Geriatric Solutions release medical information to specified persons other than you? Yes ________ No ________

If yes, please specify to whom this information may be released.:

Authorized Person	**Relationship to You**
____	____
____	____
____	____

I understand that as part of my continuing healthcare, my physician maintains medical records in his/her office, which contain my health history, symptoms, examination test results, diagnoses and treatment plans, to be used as a basis for planning my care and treatment, and that this information may be released to my other physicians/healthcare providers.

I understand that I have the right to request restrictions as to how my medical record may be used or disclosed.

I understand that my physician keeps on premises and on their website a copy of the "Notice of Privacy Practices for Protected Health Information" which provides a more complete description of the uses and disclosures of my medical record, and that I have been provided the opportunity to review this document prior to signing this consent, and that a written copy will be provided to me on request.

I understand that this document is a part of my permanent medical record, and that I may make changes regarding the disclosure of my health information at any time and that I need to notify my physician in writing of these changes.

Patient Signature: ____ **Date:** ____

PLEASE FILL OUT COMPLETELY AND CLEARLY. ALL INFORMATION IS REQUIRED TO CONSIDER NEW PATIENT FOR SERVICE. THANK YOU

PLEASE FAX COPIES OF ALL INSURANCE CARDS AND POWER OF ATTORNEY

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