

OUCH Sports Medical Center
GROUP HEALTH INFORMATION FORM

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

HEAD OF HOUSEHOLD: SELF or OTHER : _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____ MOBILE PHONE: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

BIRTHDATE: ____ / ____ / ____ SOCIAL SECURITY NUMBER: ____ - ____ - ____

GENDER: M F OTHER MARITAL STATUS: MARRIED SINGLE CHILD

DRIVER'S LICENSE: _____ OTHER ID: _____

EMPLOYER NAME: _____ EMPLOYER PHONE: _____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY (CARRIER): _____

SUBSCRIBER NAME: _____ SELF SPOUSE DEPENDANT OTHER

POLICY NUMBER: _____ GROUP NUMBER: _____

INSURANCE ADDRESS: _____ PHONE: _____

SUBSCRIBER BIRTHDATE: ____ / ____ / ____ SUBSCRIBER SOCIAL SECURITY NUMBER: ____ - ____ - ____

COPAY AMOUNT: _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY (CARRIER): _____

POLICY NUMBER: _____ GROUP NUMBER: _____

INSURANCE ADDRESS: _____ PHONE: _____

SUBSCRIBER: SELF SPOUSE DEPENDANT OTHER : _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

I hereby consent to the Notice of Privacy Practices currently in force by OUCH Sports Medical Center. I certify by my signature that I have read and understand the information disclosed in the above referenced notices.

I also understand that changes to this notice can be made at any time, and that it is the patient's responsibility to remain current on those changes. A copy of the current Notice of Privacy Practices will be available for inspection at the reception desk at all times, and copies of the current notice can be obtained at no charge, upon request.

ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION

I, the undersigned, have insurance coverage as stated above and directly assign all medical benefits to OUCH Sports Medical Center for services rendered by the physicians or other medical providers under their supervision. I also understand that I am financially responsible for all charges. I hereby authorize OUCH Sports Medical Center to release all information necessary to obtain payment of insurance benefits. I authorize the use of this signature on all insurance claims submitted on my behalf. I consent for care and treatment as required by the physician. I understand that there is a charge of \$20.00 for all returned checks.

UNDERSTANDING FOR SUPPLIES & OTHER DURRABLE MEDICAL EQUIPMENT

I understand that I will be responsible for all supplies and other medically necessary equipment, prescribed and/or distributed by my physician that my insurance plan does not cover

Signature of Patient/Insured/Guarantor

Date MM/DD/YYYY