ACE Medical Group

Redefining Doctor-Patient Relationships **Patient Demographic Form**

Patient Name: ____________________

Home Address: ____________________

____

City: __________ State: __________ Zip Code: __________

Home Phone: __________ Work Phone: __________ Cell Phone: __________

Email Address: ____________________

Would you like to receive e-mails of updates, newsletter information and also have our office contact you for any action that needs to be taken?

YES. I want to receive all e-mails NO. I do not want to receive e-mails

Race: __________ Ethnicity: __________ Language: __________

Date of Birth: __________ Age: ______ Sex: (M/F): ______ Marital Status: __________

Social Security #: __________ Employer: __________

Emergency Contact

Name: ____________________ Contact: ____________________

Relationship: ____________________ Previous Patient (Yes/No): __________

Preferred Pharmacy: (Please give the Pharmacy name, address and telephone. If you do not know the following please give the pharmacy name and the street name. This will ensure that your prescriptions can be called in/transcribed to the appropriate locations.)

Pharmacy Name: __________ Pharmacy Contact Number: __________

Pharmacy Address: ____________________

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Redefining Doctor-Patient Relationships **Medical History**

These questions are designed to help us get to know you and to make your first visit to ACE Medical Group more efficient and productive. THIS QUESTIONNAIRE IS FOR YOU. Many people find it helpful to organize their thoughts and make lists of important medical issues before seeing their practitioner. Feel free to skip questions you do not find helpful and do not include any information you would not want included in your medical records.

Your Name:______________________________ Date of Appointment: ____________________

CURRENT MEDICAL ISSUES

Please list any current mediccal issues you have, as well as the apporximate date each problem or issue started:

PAST MEDICAL HISTORY:
Please list important health problems or events in the past.

MEDICATIONS:
Do you take any prescribed medications? Please list medications you take daily, as well as any medications you use “as needed”. Include the dose and regimen (how often).

ALLERGIES:
Please list any known medication allergies or sensitivities, including reactions you may have had in the past to medications.

FAMILY MEDICAL HISTORY:
Please list any major medical problems they have. In particular, please note if they have a history of cancer, diabetes, heart disease under 60, hypertension, etc.

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Redefining Doctor-Patient Relationships **Insurance/Payment Agreement**

We ask that all our patients read, understand and accept our financial policies as described below. It is the policy of this office that all payments for medical services be made at the time of your visit, or before in some cases (self-pay).
Please initial the following:

Initial ____ I understand and agree that, regardless of what benefits are quoted or misquoted by my insurance company when you check my insurance status, I or another party is responsible for any deductible, co-pays or any other balance not paid by my insurance company deeming not medically necessary.

Initial ____ I understand that co-pays or co-insurance are to be paid at the time of service. Without co-pays or co-insurance, I may be charged a late fee.

Initial ____ I must provide the front desk/billing with updated information every time my insurance changes including: co-pay amount, company name, group no. and ID no.

For your convenience, we accept the following methods of payment:

- Cash
- Check (with photo ID)
- Visa
- Master Card
- Debit Card
- Discover
- Travelers Checks (with photo ID)

Full payment is due at the time of service unless we have pre-approved your insurance coverage and accepted assignment. Any required co-pays or deductibles owed by you will be collected at the time of service. If your insurance plan determines a service will not be covered, we will bill you for that charge. If we do not have contact with your insurance carrier, we cannot accept assignment to be reimbursed by your carrier. Therefore, charges are due and payable by you at the time of service. As a courtesy, we will, however, bill your insurance plan on your behalf for any service we provide with instructions to reimburse you directly.
You will bill your health plan for any hospital services we provide.
You will be responsible to pay any billed amounts upon receipt of a statement from our billing office. For Medical care provided to a minor child, the guardian or chaperone of that patient is financially responsible for charges.

- **Please notify our office of cancellation at least 24 hours prior to your scheduled appointment.**
- **Medicare beneficiaries are responsible for paying an annual deductible and 20% co-insurance.**

We are dedicated to providing you with the best care and service possible. Thank you for accepting the responsibility of prompt payment.
I have read and agree to the terms of the financial policy agreement described above.

Signature: ______________________________ Date: ______________

ACE Medical Group

Redefining Doctor-Patient Relationships **Insurance Information**

For insurance purposes, all information has to be filled out. **Please note: the Guarantor is the name that appears on the insurance card.** If you are a Tricare Patient, please make sure that each section is filled out. The Guarantor will be the individual who is currently or has served in the Military. Please note that our office has to have the Guarantor's Birthdate and ID No. Please note that the ID Number is the card holder's Social Security Number.

Primary Insurance

Cardholder's Full Name

First: ____________________ **Middle:** ____________________ **Last:** ____________________

Primary Insurance Plan: ____________________

Group No.: ____________________ **ID No.:** ____________________

Guarantor's Name (Last, First, Middle): ____________________

Guarantor's Date of Birth: ____________________

Insurance Address: ____________________

Secondary Insurance:

Cardholder's Full Name

First: ____________________ **Middle:** ____________________ **Last:** ____________________

Primary Insurance Plan: ____________________

Group No.: ____________________ **ID No.:** ____________________

Guarantor's Name (Last, First, Middle): ____________________

Guarantor's Date of Birth: ____________________

Insurance Address: ____________________

ACE Medical Group

Redefining Doctor-Patient Relationships **Release of Healthcare Information**

This form is giving the permitted individuals listed below authorization to receive information on your medical condition (e.g. test results, hospital status, appointment information, pick-up records/prescriptions, etc.)

I, ____ give ACE Medical Group permission to release medical/billing information to the following individuals:

1. Name:________________________________ Relationship:__________________________

   Phone:________________________________ Previous Patient: Yes No

2. Name:________________________________ Relationship:__________________________

   Phone:________________________________ Previous Patient: Yes No

3. Name:________________________________ Relationship:__________________________

   Phone:________________________________ Previous Patient: Yes No

Patient Signature: ______________________________________ **Date:** ____________________

Notice of Privacy Policy

Your name and signature on this sheet indicate that you have received a copy of ACE Medical Group's Notice of Privacy Practices and Patient's Bill of Rights on the data indicated. If you have any questions regarding the information in ACE Medical Group's Notice of Privacy Practices, please do not hesitate to contact a clinic representative as indicated on your Notice.

Date: ____________________
Patient Name (Please Print):____
Patient's Signature: ____

If Patient is under the age of 18
Date: ____________________
Patient Representative Name (Please Print): __________________________________
Patient Representative Signature:____

ACE Medical Group

Redefining Doctor-Patient Relationships **Release of Healthcare Information**

Patient Name: ______________________ Date of Birth: ______________________

Patient's PCP: ______________________ Social Security No.: ______________________

I request and authorize ______________________ to release
Healthcare information of the patient named above to:

Name: ______________________

Address: ______________________

City: ______________________ State: ______________________ Zip Code: ______________________

This request and authorization applies to:

- ☐ Healthcare information relating to the following treatment, condition, or dates:

  ____

- ☐ All healthcare information

- ☐ Other: ______________________

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ______________________ Date Signed: ______________________

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