Russell A. Smith, MD Alicia Jones, MD
Miquelle Smith, NP Brooke Ludwig, NP

PATIENT INFORMATION

Patient Name:_____Birthdate:_____

Address:_____City, State, Zip:_____

Cell Phone:_____Home Phone:_____Work Phone:_____

Which is the best contact: ***(circle)*** CELL HOME WORK Email:_____

Preferred Pharmacy:_____ Approx Address & City:_____

Preferred COMPOUNDING Pharmacy:_____

Marital Status: ***(circle*)** Single Married Partner Separated Divorced SSN#**:**_____

Who Referred you to our office? _____

Who, Besides yourself, can we release information to: _____

Relation: _____ Phone Number:_____

If a patient is a *minor*, who can receive information? _____

Relation: _____ Phone Number:_____

Name of Person(s) to contact in case of emergency:

Name: _____Phone Number:_____ Relation:_____

Name: _____Phone Number:_____ Relation:_____

INSURANCE INFORMATION

***** Please fill out <u>completely</u>, and give cards and picture ID to front office staff**

Primary Insurance:_____ Policy Holder:_____

Policy Holder's Birthdate:_____ Relationship to Patient:_____

Policy #: _____ Group #:_____

Secondary Insurance:_____ Policy Holder:_____

Policy Holder's Birthdate:_____ Relationship to Patient:_____

Policy #: _____ Group #:_____

PLEASE CIRCLE YOUR PROVIDER:

RUSSELL A SMITH, MD ALICIA JONES, MD Brooke Ludwig, NP MIQUELLE SMITH, NP

Patient Name:_____ Date of Birth: _____

Please *INITIAL* that you have / received each of these items:

_____ **Consent to treat**: I have read the consent to treat and fully understand its contents.
Initial here

_____ **Consent to EMAIL or TEXT**: I give consent to email or text appointment reminders or other healthcare communications.
Initial here

_____ **Notice of privacy Practices**: I have read the privacy notice and understand the content.
Initial here

Lab Consent Policy

I understand that neither Miquelle Smith NP nor any of her staff know what my insurance benefits are for labs.
I understand that I am responsible to call about my coverage if I am concerned about what will be covered.
I understand that Miquelle Smith NP will order what she feels is medically necessary based on our visit. If I choose to not have this lab work done she may not be able to treat me. This has been explained to me, and I am fully aware that I will be responsible for the charges that are not covered by my insurance. I further understand that the office will not add or change codes after labs are drawn if there is no documentation to support this. _____
Initial here

Payment Policy:

Our Office, as a courtesy to you, will bill the insurance carrier for the service performed by Dr. Russell Smith, Dr. Alicia Jones, Miquelle Smith and Pamela Sunshine or any nursing staff. Co-Pays are requested at the completion of each visit if applicable. If you do not have insurance, please discuss your payment needs with the office manager.

I also Hereby authorize the release of any medical information necessary to process insurance claims. I hereby assign and transfer any insurance benefits due to me to them. I understand that I am financially responsible for any unpaid balance on my account after insurance payments and adjustments.

It's understood and agreed that if I fail to pay for my account in accordance with these terms. I will pay all costs of collection, including reasonable attorney fees, court costs and up to 50% collection fee.

I have read and understand the financial and Lab policy of this office.

Signed:_____ Date:_____

Parent/Guardian of Minor:_____ Print Name:_____