Family Practice Associates of Upper Dublin

Patient Data

Name: _____ _____ **Gender**: M F TG
(Last) (First) (Middle) (Suffix or title)

Date of Birth: _____/ _____/_____ **S.S.N.** _____-_____-_____

Marital Status: S M D W Separated

Street & Apt #: _____

City: _____**State**: _____ **Zip**: _____-_____

Phone Numbers: **Preferred** ☐ **contact number?**
Home: ( )_____-_____
Work: ( ) _____- _____
Cell: ( ) _____- _____

E-mail: _____

Emergency Contact Person:

Name: _____
Relationship: _____
Phone: _____

Is this person your Care Giver? Y or N

Do you have an Advanced Directive? Y or N

Race (check applicable): □ ***Asian*** □ ***Black or African American*** □ ***American Indian or Alaska Native*** □ ***White***
□ ***Native Hawaiian or other Pacific Islander*** □ ***Other*** □ ***Unknown/undetermined***
Ethnicity (check applicable): □ ***Hispanic/Latino*** □ ***Non-Hispanic/Non-Latino***
Preferred language (check applicable): □ ***English*** □ ***Spanish*** □ ***Portuguese*** □ ***Korean*** □ ***Other***

Responsible Party

The Responsible Party is the person who will be responsible for any unpaid balances after insurance payments.

Name: _____ _____
(Last) (First) (Middle) (Suffix or title)

Street: _____

City: _____**State**: _____ **Zip**: _____-_____

Preferred Phone Number :( )_____-_____

Date of Birth: _____/ _____/_____ **S.S.N.** _____-_____-_____

Relation to Patient: _____

Power of Attorney Information:

Name: _____
Addr: _____
Phone: _____

The Insurance Subscriber is the person who is the "holder" of the insurance policy covering the patient.

Name: _____ _____
(Last) (First) (Middle) (Suffix or title)

Street: _____

C**ity:** _____**State**: _____ **Zip**: _____-_____

Preferred Phone Number :( )_____-_____

Date of Birth: _____/ _____/_____ **S.S.N.** _____-_____-_____

Relation to Patient: □ ***Self*** □ ***Spouse*** □ ***Parent*** □ ***Other*** **Employer:** _____

Other

	Insurance Carrier	Policy Number	Group Number	Subscriber Name / Relationship to Patient
Primary				
Secondary				

Preferred Pharmacy Name & Phone :_____

Prescription Plan Name, Phone and ID # : _____

_____

(Please provide a copy of your prescription plan card if applicable)

Other Physicians you see: _____

Updated 12/2018 - Family Practice Associates of Upper Dublin

Please sign below. This is required for your benefits to be paid directly to the practice.

REQUEST FOR PAYMENT AND ASSIGNMENT OF BENEFITS

I request payment and authorize any healthcare benefits that are otherwise payable to me by any insurance provider, benefit plan or other third-party payer, under the terms of the insurance policy or benefit plan be paid directly to FPUD Health Providers I understand that:

* I may be responsible for payment in full of any amount due that is not covered or paid for by any insurance policy or benefit plan.
* If my account is referred to an attorney or agency for collection of any unpaid balances for which I am responsible, that I will also be responsible for reasonable attorney's fees and collection expenses.
* My obligation to pay may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.

RELEASE OF INFORMATION

I authorize AHP and/or their agents:

* To give the insurance provider, benefit plan, or other third-party payer, or their agents, any medical or other information necessary to receive payment or obtain authorization for services, supplies and equipment.
* To request and receive directly, on my behalf, any information related to my insurance policy or benefit plan (including, but not limited to, proof of my healthcare benefits).
* To file, on behalf of themselves or on my behalf, claims for benefits and/or appeals of any denied claims or authorization and to take action in my name against any insurance company, benefit plan or other third party payer, to receive any benefits that may be due or payable under the insurance policy or benefit plan.
* To give medical or other information to any healthcare practitioner providing healthcare services to me or receive information from them.

STATEMENT OF ASSISTANCE

I agree:

* To assist FPUD in collecting benefits that may be due or payable under my insurance policy or benefit plan for the services, supplies and equipment provided.
* To provide any additional information needed to process the claim for payment.
* That a photocopy or other reproduction of this document shall be considered as valid as the original.

_____ _____ _____

Signature of Patient / Signature of Person Authorized to Consent for Patient ***Relationship to Patient*** ***Date***

_____ _____

Signature of Witness ***Date***

_____

If the patient is unable to sign upon arrival, state the reason and initial

I certify that the information on this form is correct and current:

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

For office use only:
Authorization Number_____ Dates _____ Review necessary? _____

Form should be completed at patient's first visit, whenever changes are indicated or at least annually per policy.

Updated 12/2018