GILMAN FAMILY PRACTICE (Adult 19+)

Patient Information

Last Name:___________________________ **First Name:**________________________ **Middle Initial:**___________________

Mailing Address:____

City:___________________________________ **State:**_____________________________ **Zip:**_______________________

Home Phone:_________________________ **Cell Phone:**__________________________**Work Phone:**________________

Birthdate:______________________ **Soc Sec #:**__________________________**Email address:**________________________

Gender: _______**Male** ________ **Female** _____**Other /Specify:**______________________________

Marital Status: ______ **Married** _______**Single** ______**Widow/er** ______**Divorced/separated**

Name of Spouse/Partner:________________________ **Pharmacy:**_______________________**Location:**___________________

Race:___White/Caucasian _____Black/African American _______Native Hawaiinan/Other Pacific Islander
______Asian _____American Indian or Alaskan Native ______Other _____Refuse
Ethnicity: _______ Hispanic or Latino _______Non Hispanic or Latino ______Other ______Refused

_____**Employed** **Occupation/Employer:**________________________ _____**Unemployed** _____**Retired** ______**Disabled**

Emergency/Alternate Contact:__________________________**Relationship:**_________________**Phone#**______________________

Primary Insurance Information

Ins Co Name: ____________________________________

ID#_________________________ **Group#**___________

Subscriber Name:_________________________________

Birthdate:______________**Relationship:**_____________

Employer:_______________________________________

Secondary Insurance Information

Ins Co Name:_______________________________________

ID#_________________________ **Group#**_______________

Subscriber Name:____________________________________

Birthdate:________________**Relationship:**______________

Employer:____

Release of Benefits Information:

I authorize my insurance benefits to be paid directly to Gilman Family Practice for services provided by them. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible at the time of service for all copays, deductibles, and non-covered services. I give Gilman Family Practice permission to release my private health information required for treatment, referrals, payment, claims, and healthcare operations.

All COPAYS ARE DUE AT TIME OF SERVICE

Do we have permission to leave a DETAILED message of you medical information on your voicemail? ___**Yes** ___**N0**

If yes, which phone? _______________________

Do we have permission to discuss your protected health information with a family member, caregiver, or other person? ___ **YES** ___**NO**

If yes, whom?____ **Relationship:**______________________________________

Private health information pertaining to HIV, Sexually Transmitted Diseases, Mental disorders, Drug and Alcohol abuse/rehab and/or reproductive health will not be discussed with anyone other than the patient per office policy unless the patient is present.

Patient Signature:____ **Date:**___________________________

Authorized Representative (if applicable):____

CONTINUE ON REVERSE SIDE…

Informed Consent for Telemedicine Services

Today's Date: ______________________

Patient Name:___________________________ Patient DOB:_________________

Telemedicine is a way to get health care from home. Telemedicine visits let you and your provider meet by video, web portal, or other technology. This means that you will not be in the same room as your provider. A note about your visit will be placed in your health record and may be shared with others who are helping with scheduling or billing.

You may stop the telemedicine visit at any time. Your provider may also stop the visit if they are worried about the connection quality or if they believe that you need to be seen in person.

Risks and other problems may occur such as equipment or internet failure or poor internet connection which could make it hard for the provider to see how you are doing and may result in more time before diagnosis and/or treatment.

Knowing the risks and benefits, I consent to Telemedicine Services with Gilman Family Practice. Depending on my coverage, I understand there may be a **copayment, deductible,** and **cost sharing** for Telemedicine Service. If I have any questions regarding coverage, I understand that it is my responsibility to contact my insurance provider and I agree to pay outstanding balances not covered by my insurance.

The consent is active for a period of one year from today.

____

Printed Name if signing for the patient

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Patient/Parent/Guardian Signature

**Telemedicine Services offered by Gilman Family Practice adhere to HIPAA Privacy and Security laws.*