Full Name: _____ **DOB:** _____

Social Security #: _____

Gender at Birth (circle one): Male Female

Race (circle one): American Indian/Alaska Native Asian African American/Black

Native Hawaiian/Other Pacific Islander White Other: _____

Ethnicity: Hispanic Non-Hispanic

Marital Status (circle one): Single Married Divorced Separated Widow

Address: _____

Street City State Zip

Preferred Phone Number: _____ Home/Cell/Work

Email Address: _____ I would like to be web-enabled € Yes € No

Pharmacy Name: _____ **Pharmacy Phone Number:** _____

Emergency Contact Information

Full Name: _____ **Relationship to patient:** _____

Contact Phone Number: _____

Insurance Information
(**Only** complete if you do not have your insurance card)

Insurance Company: _____ **Member ID:** _____

Group Number: _____ **Copayment:** _____

Subscriber Name: _____ **Subscriber DOB:** _____

I CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS CORRECT AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PROVIDER. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR COPAYS, DEDUCTIBLES AND COINSURANCES, AS WELL AS NON-COVERED SERVICES, AS DETERMINED BY MY CONTRACT WITH MY INSURANCE CARRIER. I AGREE TO PAY THE AMOUNT DUE AFTER MY INSURER HAS MADE PAYMENT TO MY PROVIDER.

Patient or Guardian' Signature: **Date:**

ACKNOWLEDGEMENT OF NOTIFICATION OF PRIVACY PRACTICES

im HEALTH

I, _____ DOB _____, acknowledge that I have been notified of this practice's privacy policy that includes medical and prescription history, and a written copy of this policy has been made available to me. I authorize medical treatment as deemed necessary and appropriate by the medical providers of ***IM | Health*** and their employees participating in my care.

_____

Patient's Signature Date

CONSENT TO RELEASE MEDICAL INFORMATION

I, hereby authorize the disclosure of my protected health information (including but not limited to results, prescriptions, and appointment) to the person(s) listed below.

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

I hereby authorize the practice to leave health information and appointment reminders on

Phone Number: _____ Home/Cell/Work

€ I allow IM Health to leave messages on this phone number.

€ I allow IM Health to text this phone number.

€ Web enable email address

_____

Patient Financial Responsibility Form/Self-Pay Waiver

Thank you for choosing **IM | Health** for your medical needs. We are committed to providing you the highest quality healthcare, but we are not a collection agency.

Patient Financial Responsibilities

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care. **Please select ONE below:**

⬜ **Check here** if you agree to the **self-pay rate for services rendered, at time of service.**

- I voluntarily choose to receive treatment from this provider and agree to pay in full for all services rendered. I understand that I am personally responsible for all charges incurred and that payment is due at the time of service.
- I understand that the provider named above is not enrolled as a Medicaid provider and does not accept Medicaid as payment for services.
- I understand that Medicaid will not pay for any services I receive from this provider. I acknowledge that I cannot submit a claim to Medicaid for reimbursement.

⬜ **Check here** if you elect to use available medical insurance for visit coverage. You may be responsible for a copay or deductible per your insurance provider.

- We will bill your insurance for you, however the patient is required to provide the most correct and updated information regarding insurance.
- Copayments are due at the time of service.
- Patients are responsible for payment of copays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
    - **You will NOT receive a bill. Your credit card on file will be charged, and a receipt published to your patient portal.**

WE ARE NOT A COLLECTION SERVICE.
You will be charged for any balance your insurance contract designates as your responsibility.

*Please note when choosing **either** of the above options; **A VALID CREDIT CARD ON FILE WILL BE REQUIRED PRIOR TO SERVICE.**

By my signature below, I hereby authorize assignment of financial benefits directly to **IM | Health** and any associated entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment. **I also accept the fees charged as a legal and lawful debt and agree to pay said fees, including any/all collection agency fees, if such be necessary.** I understand that **IM | Health** does not participate with any Medicaid/QMB products and that I will be responsible for any balances resulting from my care.

_____ _____

Patient Name **Date of Birth**

_____ _____

Patient or Parent/Guardian Signature **Date**

Transfer of Records Request

I, _____ DOB: _____, hereby authorize IM Health to obtain my records from:

Doctor/Facility Name: _____

im | HEALTH

_____

Street City State Zip

Phone Number: _____ Fax Number: _____

Checking the following items grants specific permission for the designated information to be released or obtained from the above named party:

€ Immunization records

€ Physical Exam – **within the last year only**

€ Labs – **within the last year only**

€ Colonoscopy

€ Diagnostic Imaging to include Mammogram, EKG, X-rays, MRIs

€ Specialist Consults

I understand that I may revoke this authorization at any time in writing. If not sooner revoked, this authorization shall be valid for the period of time necessary for continuing care, the processing of claims or the completion of peer review. By signing this form, I relieve IM Health of any responsibility regarding previous records obtained from any other medical practices.

Signature of Patient/Guardian: _____ Date: _____

PLEASE DO NOT FAX IF RECORDS EXCEED 25 PAGES; MAIL TO OUR OFFICE AT THE ADDRESS BELOW.

372 W LANCASTER AVE
WAYNE PA 19087

im HEALTH