IMH Physical Medicine

Full Name: _____ **DOB:** _____

Social Security #: _____ **Gender (circle one):** Male Female

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

Native Hawaiian/Other Pacific Islander White **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

Primary Care Provider: _____ **PCP 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's Signature: _____ **Date:** _____

Physical Medicine

im HEALTH

ACKNOWLEDGEMENT OF NOTIFICATION OF PRIVACY PRACTICES

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.

_____

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.