

**** 18+ YEAR ****

CTMC-Patient Demographic Form

Patient Information:

Last Name (Legal):	First Name (Legal):	Full Middle Name:	Date of Birth (DOB): Month: _____ Day: _____ Year: _____
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Do you elect to authorize CTMC to share information within your medical record: <input type="checkbox"/> Decline <input type="checkbox"/> Yes (please list):		College/School attending: _____
	Name: _____	Relation: _____	Place of employment: _____
	Name: _____	Relation: _____	

RACE (please check) White American Indian/Alaskan Native Asian Black/African American Hispanic/Latino Native Hawaiian/Other Pacific Islander
 Chose not to disclose Unknown

ETHNICITY (please check) United States Iran Iraq Laos Lebanon Mexico Russia Serbia Somalia China
 Declined Other: _____

PRIMARY LANGUAGE (please check) English Arabic Hmong Laotian Russian Sign Language Somali Spanish Thai Urdu Chose not to disclose
 Other: _____ **Do you require an interpreter: Y/ N**

Patient Address:	Apt/Unit	City/State	Zip Code/County
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<p>Contact information:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Home #</td> <td style="width: 15%;"></td> <td style="width: 70%;">Ok to leave a message here: <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Cell#</td> <td></td> <td>Ok to leave a message here: <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Work#</td> <td></td> <td>Ok to leave a message here: <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>	Home #		Ok to leave a message here: <input type="checkbox"/> Yes <input type="checkbox"/> No	Cell#		Ok to leave a message here: <input type="checkbox"/> Yes <input type="checkbox"/> No	Work#		Ok to leave a message here: <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Primary e-mail address for patient portal access/medical records:</p> <p>_____</p> <p><input type="checkbox"/> New e-mail <input type="checkbox"/> Change of e-mail <input type="checkbox"/> Same e-mail that is on file</p> <p>Who's e-mail address is this? _____</p>	<p>Appointment reminders, recommended appointments and patient follow-up will be done by means of calls, voicemail, texts and/or e-mail</p> <p>Portal and Healow discussed with patient: _____ (staff only) Demo entered and verified by: _____ (Staff only)</p>
Home #		Ok to leave a message here: <input type="checkbox"/> Yes <input type="checkbox"/> No									
Cell#		Ok to leave a message here: <input type="checkbox"/> Yes <input type="checkbox"/> No									
Work#		Ok to leave a message here: <input type="checkbox"/> Yes <input type="checkbox"/> No									

Emergency Contact (s):

Name:	Relationship:	Home phone #	Cell Phone #	Are we able to contact this person in efforts to reach you? Y/N
Name:	Relationship:	Home phone #	Cell Phone #	Are we able to contact this person in efforts to reach you? Y/N

Insurance:

Primary Insurance:	Primary Insured Name:	Relationship:	DOB:	ID# Group#
Secondary Insurance:	Primary Insured Name:	Relationship:	DOB:	ID# Group#

Preferences/Information:

Primary/Preferred Provider at CTMC:	<p>Primary Pharmacy:</p> <p>Name: _____ City: _____</p> <p>Phone Number: _____</p>	<p>Allergies:</p> <p>Past Medical History:</p> <p>Family health history: Mo- Fa- Siblings-</p>	<p>Social history:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>No</th> <th>Yes</th> <th>Type/Amount</th> </tr> </thead> <tbody> <tr> <td>Tobacco exposure:</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Current smoker:</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Alcohol Use:</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Drug Use:</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Sexually active:</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Birth control:</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Depression/anxiety:</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Abuse concerns:</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		No	Yes	Type/Amount	Tobacco exposure:				Current smoker:				Alcohol Use:				Drug Use:				Sexually active:				Birth control:				Depression/anxiety:				Abuse concerns:			
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Printed name of person completing this form	I attest this information provided is correct and agree to clinic policies stated on back of form:	Date:
Name:	Signature: _____ Relationship to patient:	

***** OVER *****

CTMC CLINIC POLICIES *To show your understanding, please **initial** each section of the policies below*

In compliance with the Federal Consumer Protection Act, Child & Teen Medical Center, P.A. (CTMC) wishes to notify you of its policies regarding the financial responsibilities associated with services rendered to you or a member of your family.

1. You must present your insurance card at each visit.
2. Co-payments assigned by your insurance carrier are due at the time of service.
3. We will furnish you with a monthly statement of your account showing the amounts billed, and any payments and credits to the account
4. We will file most insurances. You are responsible for denied claims, and all patient responsibility amounts such as deductibles as per your insurance policy.
5. Payments for services are considered due and payable at the time of service unless active insurance is presented.
6. Payments are due within 30 days of billing unless payment plan arrangements are made with our Business Office.
7. Finance charges are incurred after 90 days at an 8% annual interest rate.
8. There is a returned check fee of \$35.00
9. Telehealth visits (phone, e-mail and/or web-based audio visual)/specialist consultations in lieu of an office visit may be billed to your insurance and applicable deductible/co-payment amounts will be patient responsibility.

Financial initials:

ASSIGNMENT OF BENEFITS

I hereby authorize payment of medical benefits due to me under the terms of my policy to Child & Teen Medical Center, P.A. I understand the clinic's charge may exceed the insurance company/Medicaid payment, and if greater than such, I will be responsible for paying that additional allowable amount. I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to the appointment. I will be responsible for the unpaid balance due on any bills if this is not done.

Benefits initials:

OUTSIDE COSTS

Lab tests that need to be sent out, medical equipment and visits scheduled with specialty providers within our clinic will incur separate billing outside of Child and Teen Medical Center. All billing questions for the above listed entities will need to go through that specific entity. Child and Teen Medical Center does not administer billing for these items.

Outside costs initials:

RELEASE OF INFORMATION

I hereby authorize Child & Teen Medical Center, P.A. to furnish information regarding my health care and medical history to insurance carriers and to other medical care providers to whom I might be referred by CTMC and to furnish any information necessary to complete any health forms I might submit for school camp, athletic organization or the like.

Release of Info initials:

CONTACT INFORMATION

Child & Teen Medical Center, P.A. may use my contact information for appointment reminders, follow up calls, satisfaction surveys and secure patient health information reporting through text, phone messages, and/or emails (private patient portal). You are consenting to receive directed and automated messages from us about you or your child's healthcare and hold CTMC and technology vendors harmless from any third-party claims, liability, damages or costs arising from your request to receive automated voice, text messages or from providing us, your healthcare provider, with a number that is not your own. We respect your need for privacy and will not send you telemarketing related messages or share your contact details with anyone.

Contact consent initials:

NOTICE OF PRIVACY PRACTICES

This Notice describes how the medical information about you may be used and disclosed. Please review the privacy policy attached to the new patient clip board. Please let us know if you would like a copy for your records.

Privacy Initials:

APPOINTMENT CANCELLATION POLICY

Your appointment time is reserved exclusively for you/your child. *We reserve the right to charge patients who do not reschedule with adequate notice, or who fail to show up for their scheduled appointments (more than 3 times). Patients/parents who have missed multiple appointments may be asked to seek medical care elsewhere.*

To respect the needs of other patients, we require that you contact our office to reschedule at least 24 hours prior to your scheduled appointment time. Appointments are in high demand and your early cancellation will give another patient the opportunity to be treated. To cancel an appointment, please call our office. If you do not reach a representative, you may leave a voicemail. **YOU MAY NOT CANCEL AN APPOINTMENT VIA EMAIL.**

Cancellation initials:

LATE/TARDY POLICY

If you are going to be more than 10 minutes late for your appointment, we request that you call our office. If the schedule allows, the appointment time will be shifted to accommodate the delay or you will be moved to walk-in status and not guaranteed your preferred provider. Depending upon the type of visit scheduled, we may request to reschedule the appointment. We work diligently to stay on schedule and suggest that you arrive 5-10 minutes prior to your appointment time to allow for any necessary paperwork. *Patients who are consistently late may be asked to seek medical care elsewhere.*

Late Policy initials:

I agree to all clinic policies as described above:

Signature: _____ Relationship to patient: _____ Date: _____