**PATIENT INFORMATION & RESPONSIBILITY FORM**

**PERSONAL INFORMATION:** **TODAY'S DATE: _____/_____/_____**

Patient Name: First: _____Middle: _____ Last: _____
Social Security Number:_____ Email Address:_____
Home Address: _____City: _____ State: _____ Zip:_____
Mailing Address if different: _____City: _____ State: _____ Zip:_____
Marital Status: M / D / W / S / P DOB: _____/_____/_____ Preferred Language: _____
Race:_____Ethnicity:_____
Home Phone: _____Work Phone: _____ Cell Phone:_____

**What is your current gender identity? (Check ALL that apply)**

☐ Male ☐ Female ☐ Transgender Male/Transman/FTM ☐ Transgender Female/Transwoman/MTF ☐ Gender Queer
☐ Additional category (please specify): _____ ☐ Decline to answer

**What sex were you assigned at birth? (Check one)**

☐ Male ☐ Female ☐ Other

**Emergency Contact**

Name: _____ Relationship: _____ Phone #:_____
Employer Name: _____Position: _____ Phone #: _____
Referring Physician: _____ Phone #: _____

**INSURANCE INFORMATION: You will be asked for a copy of your insurance card(s) at each visit.**

Is the Insurance in your name? Y / N If no, who carries this insurance: _____ DOB: ____/_____/____
Primary Ins: _____ID #: _____ Group #: _____
Ins Phone #: _____ Address: _____Effective Date: _____
Secondary Ins: _____ ID #: _____ Group #: _____
Subscriber's Name: _____ DOB: ____/_____/____
Ins Phone #: _____ Address: _____ Effective Date: _____

**RESPONSIBLE PARTY (IF OTHER THAN SELF, OR IF PATIENT IS A MINOR**):

Name: _____DOB: _____/_____/_____ Social Security Number: _____
Relationship: _____Email Address: _____
Home Address: _____ City: _____ State: ____Zip: _____
Mailing Address: _____ City: _____ State: ____ Zip:_____

**ASSIGNMENT OF BENEFITS:**

By signing this form, I authorize Elevate Health, on behalf of my provider, to bill my insurance and release any information necessary to secure payment of benefits. I acknowledge that I am financially responsible for all the charges whether paid by the insurance or not. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I the undersigned, agree to pay for all the costs and expenses, including reasonable attorney fees. I hereby authorize assignment and payment of major medical benefits due to me to the Elevate Health. A photocopy of this assignment is to be considered as valid as an original.

**AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:**
I certify that I had the opportunity to review and read a copy of the Elevate Health Privacy Policy. I hereby authorize Elevate Health or the provider individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

**AUTHORIZATION TO CALL, MAIL, OR E-MAIL:**
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize Elevate Health representatives or my provider to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Elevate Health to that effect in writing.

Phone to call or message me: _____Email: _____

**LAB/RADIOLOGY/DIAGNOSTIC SERVICES &/OR MEDICATIONS:**
I understand that I may receive a separate bill if my medical care includes lab, x-ray, other diagnostic services, or medications. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

**CONSENT TO TREATMENT:**
I hereby consent to evaluation, testing, and treatment as directed by my Elevate Health provider.

| Patient Signature or Guarantor | Date |
|---|---|
| Description of Guarantor's Authority, if required. | |