RYAN FAMILY PRACTICE

300 S Rath St Suite 202 • Ludington, Mi 49431 • Phone 231-425-4447 • Fax 231-425-4401

Date

PATIENT INFORMATION

Name: (Please Print)	**Maiden /Other Name**	**Social Security Number:**
Address: Email Address:		**Birthdate:**
City: **State:** **Zip:**		**Age:**
Race: **Religion:** **Sex:** ☐ **Male** ☐ **Female**		**Marital Status:** **M** ☐ **S** ☐ **W** ☐ **D** ☐ **Separated** ☐
Home Phone:	**Cell Phone:**	**Work Phone:**
Employer:		**Phone:**
Address: **City:** **State:** **Zip:**		
Emergency Contact :	**Relationship:**	**Phone:**

INSURANCE INFORMATION (Please provide insurance cards for coping)

Primary Insurance:	**Policy Number:**	**Name of Person on Insurance Card:**	**Birthdate of person on card**
Secondary Insurance:	**Policy Number:**	**Name of Person on Insurance Card:**	**Birthdate of person on card**

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)

I hereby consent that **Ryan Family Practice** use and disclose my protected health information to carry out treatment, payment, or health care operations. You may revoke this authorization in writing at any time by sending written notification. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

I give permission to: **Ryan Family Practice** to disclose the following protected health information to:

_____

(example: spouse, children, mother, father, significant other) Please enter **NONE** if you do not want any information to be given out.

_____Date_____

Signature

AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

I authorize **Ryan Family Practice** and any treating physicians performing services at this facility to release to the Social Security Administration and the Centers for Medicare and Medicaid Services, their intermediaries or other carriers, any information needed for this or a related medical claim. I will permit a copy of this authorization to be used in place of the original and I request payment of medical insurance benefits to the party who accepts assignment.

I authorize payment to **Ryan Family Practice** of the medical insurance benefits otherwise payable to me, but not to exceed the charges for this encounter. I understand that I am responsible for payment of these services, including services considered non-covered per my insurance plan when ordered by my physician or per my request. A photo copy of this authorization shall be considered as effective and valid as the original.

I understand that I am personally responsible for all fees regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made.

_____Date_____

Signature