Stone Creek Family Medicine

Dr. Jeremy McWilliams

Please Complete Each Section:

Patient Information:

Patient Name _____

Patient SS#: _____

Address: _____

City, Zip: _____

HM Phone: _____

Cell Phone: _____

MARITAL STATUS: S M W DIV SEP

Date of Birth: _____

Place of Employment: _____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY:

Name: _____

Address: _____

City,Zip: _____

Phone #: _____

WK #: _____

Relationship to Patient:

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED PERSONS:

Spouse: _____

My Children: _____

Other: _____

*May not be given to anyone than myself: _____

I hereby authorize medical information to be relayed to me via:

Hm Phone: _____

Cell Phone: _____

Email Address: _____

Left on voice mail/Answering machine: _____

REFERRALS: Require office visit and 72 hours to obtain insurance authorizations

Person Responsible for bill/Insurance:

Name: _____

Date of Birth: _____

SS#: _____

Address: _____

City, Zip: _____

Phone #: _____

Relationship to Patient: _____

Employer: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

I acknowledge that I was provided a copy of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice. I acknowledge that I am responsible for following my physician's recommendations and I understand that the sole responsibiltiy of my health & well being is in my hands in view of the above and that I cannot reasonably hold my physician responsible if I do not adhere to his recommendations and/or take medications as I am instructed to do so.

PLEASE MAKE SURE WE HAVE A COPY OF YOUR INSURANCE CARD(S). THANKS

I authorize Stone Creek Family Medicine Physicians and /or Physician Assistants to furnish any information to my insurance company in order to process my claim. I grant permission to release medical records as necessary I understand that I am responsible for my expenses unless assignment is accepted and that my insurance company is a contract between myself and the insurance company. I understand that payment is expected at the time of service unless prior arrangements have been made. I do agree for my insurance payments to go to Stone Creek Family Medicine Physicians and/or Physician Assistants, unless I have paid my balance in full at the time of service. All returned checks incurr a $100 fee per check. A $10 billing fee will be charged for statements over 60 days.

Responsible Party Signature

RX REFILLS: Allow 24 Hours Monday - Thursday
Friday - 1st Following Working Day