EASTBROOK FAMILY HEALTH CENTER
PATIENT INFORMATION

Date _____

Welcome to Our Office. Please complete this form every 12 months so we can accurately record needed information.

PATIENT'S LEGAL NAME (LAST, FIRST, MIDDLE)		ADDRESS		CITY, STATE & ZIP
SS#	PRIMARY PHONE ❑ Home ❑ Work ❑ Cell	SECONDARY PHONE ❑ Home ❑ Work ❑ Cell		MARITAL STATUS S M W D Sep
BIRTHDATE	SEX M F	PATIENT'S EMPLOYER	OCCUPATION	WORKING HOURS
SPOUSE (OR PARENT'S NAME IF PATIENT IS UNDER AGE 18)			HIS/HER SS#	HIS/HER BIRTHDATE
IN CASE OF EMERGENCY, CONTACT		HIS/HER HOME PHONE #		HIS/HER WORK PHONE #
PATIENT'S EMAIL ADDRESS			CONSENT TO ONLINE ACCESS VIA FOLLOW MY HEALTH? ❑ YES ❑ NO	
LIST ANY LANCASTER COUNTY FAMILY PRACTICE OFFICE WHERE YOU HAVE BEEN A PATIENT IN THE PAST 3 YEARS				
IF NOT LOCAL RESIDENT, GIVE TEMPORARY ADDRESS AND PHONE		GIVE NAME(S) OF FAMILY MEMBERS WHO ARE OUR PATIENTS		

All charges are due at the time of service unless covered by an insurance accepted by the practice. Please present a valid photo ID along with all insurance cards to the receptionist so a copy may be placed in your record. Worker's Compensation and Auto Accident require an additional form. Eastbrook Family Health Center is a member of Physicians Alliance Limited. Billing is done by Physicians Alliance Limited.

Please read and sign:

I authorize Eastbrook Family Health Center to release to hospitals, specialists, pharmacies, prescription plans, and other entities caring for or providing for my physical or mental health, any medical information, mental health records, HIV-related information, and drug and alcohol treatment records needed for my care. This information may be delivered via voice/telephone, fax, mail, or internet.

I give permission to Physicians Alliance Ltd. and its authorized employees, agents, and medical providers to release to insurance carriers, health maintenance organizations, governmental agencies, and other entities or individuals charged with the fiscal responsibility for the payment of services rendered to me, any medical information, psychiatric/psychotherapy records, mental health records, HIV-related information, and drug and alcohol treatment records needed to determine benefits payable to Eastbrook Family Health Center services. This information may be delivered via voice/telephone, fax, mail, or internet. I hereby authorize payment of the benefits otherwise payable to me to be paid directly to Physicians Alliance Ltd. and/or the appropriated provider. I consent to having any monies received by the provider of services on my behalf to be applied to my outstanding accounts. It is my responsibility to know which services my insurance(s) considers non-covered. I assume full responsibility for payment of any charges for the services provided. I acknowledge and understand that in order to facilitate billing and related activities, my medical information will be maintained by Physicians Alliance Ltd. on its computer network and that all such information will be subject to appropriate measure to protect confidentiality.

I am aware of the office procedures and policies: A 24-hour notice is required for all referrals. A 48-hour notice is required for prescription refills or a rush charge will apply. All forms must be presented at the time of service or additional fees will be charged. Please notify us as soon as possible if you are unable to keep an appointment. A no-show for an appointment will result in a charge being applied to your account.

This authorization will stay in effect unless revoked by me in writing.

Signature _____ Date _____