

EAST GRANBY FAMILY PRACTICE

PATIENT INFORMATION SHEET

ADDRESS UPDATE

IMPORTANT: Please select and circle your Primary Care Physician

Dr. Ewald	Dr. Howlett	Dr. Ghumman
Dr. Freedman	Dr. Reiher	Dr. Lerner
		Dr. Pursnani

PATIENT INFORMATION

Please Circle:

Name _____
 Address _____
 Town _____
 State _____ Zip _____
 SSN _____ - _____ - _____
 Employer _____
 Language English Spanish French Other _____

Sex: Female Male
 Marital Status: Single Married Widowed Divorced Separated
 Date of Birth _____ / _____ / _____
 Patient Home () _____
 Patient/Parent Work () _____
 Patient/Parent Cell () _____

PHARMACY INFORMATION

Please circle preferred number - Home Work Cell

Name _____
 Town _____
 Pharmacy Phone/Fax # () _____

E-Mail _____
 Emergency Contact _____
 Contact Phone # () _____
 (preferably outside household)

PATIENT RESPONSIBILITIES

To assist our patients to understand their financial responsibilities to the practice and additional charges that may be applied to non-payment, missed appointment, cancelled appointments, etc., please note the following:

- ▶ I agree to pay **\$50.00** fee for any appointment missed or if I fail to notify the office **24 hours** in advance.
- ▶ If I fail to pay my co-payment at time of my appointment, I agree to pay a **\$10.00** billing charge.
- ▶ In divorce cases, remember that the adult seeking treatment is responsible for the bill regardless of their own personal problems. If the court has awarded custody of minor children to one person and financial responsibility to another, **the person bringing the child is responsible for payment of those services at the time of their visit.** A receipt can be provided should you wish to bill your estranged.
- ▶ I agree to pay **\$25** fee for any check that is returned by my bank.
- ▶ If I fail to pay my bill in a satisfactory manner within **60** days and the account is assigned to a collection agency, I will pay the costs of a one time collection fee of **\$25.00**. If required I will also be responsible for attorney's fees.
- ▶ I understand that the office can only bill for a diagnosis documented in my record, and that to ask the doctor to change a diagnosis to secure insurance payments constitutes fraud.
- ▶ We ask that each of our patients now take the responsibility of knowing what their specific health benefits are. Our office will continue to submit insurance claims as a courtesy to our patients. However, we regret that we can no longer commit to knowing what each insurance company will pay on any given procedure.

AUTHORIZATION AND RELEASE: I hereby authorize payment for any services on my behalf be made directly to the doctor. I understand that I am responsible to the doctor for charges not covered by my insurance company. I hereby authorize my physician to release any information required to support my claim, treatment, health care operations and for other purposes that are permitted or required by law.

 Patient's Signature or Legal Guardian (Specify relationship to patient)

 Date

Do you have an advanced directive/living will? (please circle)
 If yes, please provide a copy to the doctor.

YES NO