EAST GRANBY FAMILY PRACTICE
PATIENT INFORMATION SHEET

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

Name _____

Address _____

Town _____

State _____ Zip _____

SSN ___ - ___ - _____

Employer _____

Language English Spanish French Other _____

PHARMACY INFORMATION

Name _____

Town _____

Pharmacy Phone/Fax # ( ) _____

Please Circle:

Sex: Female Male

Marital Status: Single Married Widowed Divorced Separated

Date of Birth ___ / ___ / _____

Patient Home ( ) _____

Patient/Parent Work ( ) _____

Patient/Parent Cell ( ) _____

Please circle preferred number - Home Work Cell

E-Mail _____

Emergency Contact _____

Contact Phone # ( ) _____

(preferably outside household)

If this information is not completed IN FULL, your claim may be denied by your insurance company, and become your responsibility. We destroy the previous sheet, old information is not transferable. PLEASE COMPLETE!

INSURANCE INFORMATION	**PRIMARY**	**SECONDARY**
INSURANCE CO.		
ID #		
GROUP #		
SUBSCRIBER INFORMATION		
Subscriber Name		
Subscriber SSN	- -	- -
Subscriber DOB	/ /	/ /

Subscriber is: Self Spouse Parent Significant Other other (specify)

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

OVER ------->> **OVER ------->>** **OVER ------->>** **OVER ------->>**

Acknowledgement of Receipt of Notice of Privacy Practices

East Granby Family Practice, L.L.C.

13 Church Road, P.O. Box 518
East Granby, CT 06026
Attention: HIPAA Compliance Team
(860) 653-4526

Name of Patient: _____ **D.O.B.** _____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient: _____

_____

Do you have an advanced directive/living will? (please circle) **YES** **NO**
If yes, please provide a copy to the doctor.
