CLEAR CREEK CLINIC, P.A.
PATIENT INFORMATION FORM
(PLEASE COMPLETE ALL QUESTIONS)

Patient Name:_______________________________________ Sex: __ M __F Date of Birth: _______________
Address: _______________________________ City: ______________ State: _____ Zip code: ___________
Marital Status: __ S __ M __ D __ W SS#: ____________________ Drivers License #: ___________________
Home Phone #: _________________ Work Phone #: _________________ Cell Phone #: _________________
e-mail:________________________________ Preferred Method of Contact: __Mail __Home Phone __Cell Phone
Race: __African American __White __Hispanic __Non-Hispanic __Other **Ethnicity**: __Hispanic __Non-Hispanic
Preferred Language: ____

Parent or Guardian Name: _______________________________________ Date of Birth: ______________
Address: _______________________________ City: ______________ State: _____ Zip code: ___________
SS#: _____________________Drivers License #: _________________ e-mail: _________________________
Home Phone#: _________________ Work Phone #: _________________ Cell Phone #: _________________

Insured/Responsible Party: _______________________________________ Date of Birth:_______________
SS#: ___________________ Drivers License #: _________________ Relationship _____________________
Home Phone#: _________________ Work Phone #: _________________ Cell Phone #: _________________
Employer: ____ Employer's Phone #: ____________________
Emp. Address: ________________________________ City: ______________ State: ___ Zip code: _______

Patient's Spouse: ____ Date of Birth: _______________
Home Phone #: _________________ Work Phone #: _________________ Cell Phone #: _________________
Spouse's Employer: _____________________________________ Employer's Phone #: ___________________
Employer's Address: ________________________________ City: __________ State: ___ Zip code: _______

Emergency Contact: _______________________________________ Relationship: _______________________
Home Phone #: _________________ Work Phone #: _________________ Cell Phone #: _________________

Do you have a Living Will or Advanced Directive? __Yes __No

CASH/SELF PAY PATIENTS:
I will be asked to present credit card/check/or cash payment at the time of check in with the understanding that I will be charged accordingly at the end of my scheduled visit minus a 10% discount for payment in full at the time of service.

COMMERCIAL INSURANCE: I authorize release of information necessary to file claims with my insurance company and assign benefits otherwise payable to me to CLEAR CREEK CLINIC, P.A. I understand I am financially responsible for any balance not paid by my insurance carrier. **Delinquent balances are subject to further actions**. **MEDICARE:** I request payment on authorized Medicare benefits be made on my behalf to CLEAR CLEEK CLINIC, P.A. for any services furnished to me. I authorize any holder of medical information about me to release to HCFA and its agents any information needed to determine those benefits payable for service. I hereby authorize Medicare to furnish the above named any information regarding my Medicare claims under Title XVIII of the Social Security Act. (A COPY OF MY SIGNATURE IS VALID AS THE ORIGINAL.) **MEDITECH:** I authorize CLEAR CREEK CLINIC, P.A. to obtain medical records necessary in the course of my evaluation and/or treatment. This consent is subject to written revocation by the undersigned at any time except to the extent that action has been taken. I hereby release CLEAR CREEK CLINIC, P.A. from any and all legal liability that may arise from the release of their information. The information that is requested may be sent by U.S. Mail Service and/or electronic facsimile.
PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE.

HIPAA: Acknowledgment of Review of Notice of Privacy Practices:
By signing below I am acknowledging that Clear Creek Clinic, P.A. has made available a copy of the Notice of Privacy Practices which is posted in the lobby for my review and that I am entitled to receive a copy of the printed document upon my request.

I, ____ (Print Patient Name), ___________(DOB), AUTHORIZE RELEASE OF MY MEDICAL INFORMATION TO THE FOLLOWING PEOPLE: (e.g., Jane Smith, wife)
____
____

SIGNATURE: ____ **DATE:**________________________

This signed form will serve as documentation in your medical records in compliance with Federal Government Guidelines.

CLEAR CREEK CLINIC, P.A.
CONFIDENTIAL HISTORY AND PHYSICAL

Patient Name:______________________________________ Sex: __ M __F Date of Birth: _______________
Home Phone #: _________________ Work Phone #: _________________ Cell Phone #: _________________

Pharmacy Information:
Pharmacy:____ Phone #: _____________________

CURRENT MEDICATION(S) (Include strength and dosage):____
____
DRUG ALLERGIES:____

Please provide the date of your last:

Tetanus Shot	____________	Cholesterol Test	____________
Flu Shot	____________	Rectal Exam	____________
Pneumonia Shot	____________	Bone Density Test	____________
Mammogram	____________	Prostate screening	____________

FAMILY HISTORY

Please indicate who has the problem/condition: M for Mother, F for Father, B/S for Bother/Sister,
M-A/U Maternal Aunt/Uncle, P-A/U Paternal Aunt/Uncle, M/G Maternal Grandparent, P/G Paternal Grandparent

Arthritis	____	Convulsions	____	Heart Disease	____	Migraines	____
Asthma	____	Diabetes	____	Hemophilia	____	Stroke	____
Bleeding Disorder	____	Epilepsy	____	High Blood Pressure	____	Thyroid Disease	____
Cancer	____	Glaucoma	____	Kidney Disease	____	Tuberculosis	____
Chemical Dependency	____	Hay Fever	____	Mental Illness	____		

Other ____

Please list Hospitalizations and/or Surgeries (include reasons and dates):_______________________________
____

WOMEN ONLY: Pregnant? ___ YES ___ NO Are you planning to become pregnant? ___YES ___ NO
# of Pregnancies ____ # of live Births ____ Date of Last Pap Smear ______ Date of last Menstrual Cycle _____

PAST MEDICAL HISTORY

Aids/HIV	___	Congestive Heart Disease	___	Hearing Problems	___	Mumps	___	Urinary Disease	___
Arthritis	___	Cold Sores /Blisters	___	Heart Attack/MI	___	Palpitations	___		
Asthma	___	Constipation/Diarrhea	___	Heart Murmur	___	Pneumonia	___	Venereal Disease	___
Allergies	___	Convulsions	___	Heart Problems	___	Rheumatic Fever	___		
Anemia	___	Diabetes	___	Hepatitis	___	Scarlet Fever	___	Vision Problems	___
Anxiety	___	Dizziness/Fainting	___	High Cholesterol	___	Sexual Dysfunction	___		
Birth Defects	___	Drug/Alcohol Abuse	___	Hypertension	___	Sinus Problems	___		
Bladder Problems	___	Ear Infections	___	Kidney Disease	___	Shortness of Breath	___	Other __________	
Cancer	___	Emphysema	___	Leg Cramps	___	Stroke/TIA	___		
Cerebral Palsy	___	Endocrine Disease	___	Liver Disease	___	Stomach Disorder	___	__________	
Chest Pain/Angina	___	Fatigue	___	Measles	___	Tuberculosis	___		
Chicken Pox	___	Gout	___	Menstrual Dysfunction	___	Thyroid Disease	___	__________	
Epilepsy	___	Hay Fever	___	Mononucleosis	___	Ulcer	___		

HABITS: CURRENT or PAST Smoker? __Yes __NO; ___Packs Per Day; How Long _____; If quit, when_______; Exercise_____; Alcohol __YES __NO; Diet/Salt Restriction __YES __NO; Cups of Coffee_____; Vitamins____________________; Sleep Pattern________; Food Intolerance __YES __ NO (if yes, please explain)________________; Illicit Drug Use __YES __NO; Herbs ____________; Guns in the Home __YES __NO; Travel Outside of the USA? __YES __NO (If yes, where? when?) ______________________________________

SIGNATURE: ____ **DATE:**________________________

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CLEAR CREEK CLINIC PATIENT PAYMENT POLICY

As part of our commitment to offer excellent medical and professional care to you and your family, we would like to present our office payment policy in order to minimize misunderstandings about fees. Our fees and methods of payment are comparable with other Primary Care Physicians in the area. We ask for payment at the time of service. This includes payment for the office and any procedures and radiology performed. We commonly require payment at the time of check in. For **cash pay patients** we ask you provide us with a form of payment to hold until the end of the visit **or** you can pay in advance if this is not agreeable to you. If payment is collected in advance it will be an estimate of your charges and will be reassessed at the end of your visit.

As a courtesy, we will file all applicable office and hospital charges with your insurance carrier(s). **However, you are ultimately responsible for all charges**. We advise that you familiarize yourself with the benefits of your plan(s). Prior to any procedure, we will be available to assist you in determining your portion of the bill. This usually includes any unmet deductibles, co-payments and co-insurance which are to be paid prior to the procedure.

Any laboratory tests or specialized tests which are performed at our facility by another company (e.g., QUEST) will be billed separately by that company or facility.

From time to time your physician must request tests that are medically necessary, but may not be covered by your insurance company. If an Advanced Beneficiary Notice (ABN) form must be signed in order to allow you to receive services not covered by your insurance carrier, the form and its financial responsibility will be reviewed with you at the time of service. No services will be provided until the form is signed. After signing an ABN, you are responsible for the total charges due for services provided to you which are not covered by your insurance.

The following are allowable forms of payment: cash, check, money order, and credit card.

This policy is offered in an attempt to develop and sustain a continued professional and positive relationship. Your cooperation is greatly appreciated.

We welcome the opportunity to discuss any aspect of our financial policy with you.

Print Name:_______________________________________ DOB:_______________

SIGNATURE: ____ **DATE:**_______________________

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