PATIENT NAME____ AGE ________ DOB____________________

GENDER: M / F OCCUPATION (IF APPLICABLE) ____

ADDRESS ____ CITY ______________________STATE ______ZIP_____________

HOME PHONE (_______)__________________CELL (_______)___________________ BEST # TO REACH YOU? HOME / CELL

PRIMARY CARE PHYSICIAN: ____ PHONE NUMBER: _______________________
(A COPY OF OUR FINDINGS WILL BE SENT TO THIS PROVIDER)

LIST ANY ALLERGIES TO MEDICATIONS-**IF NONE, WRITE NONE**: ____

____

LIST ANY PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING-**IF NONE, WRITE NONE**: ______________________

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____

EMERGENCY CONTACT------- DR. HENRY WILL NOT SEE YOU WITHOUT THIS INFORMATION

NAME___________________________________ RELATION_______________________ PHONE (_____) ____________________

IS THE PATIENT UNDER 18? IF SO, WHAT IS THE NAME OF PARENT/LEGAL GUARDIAN **PRESENT WITH PATIENT TODAY**?

NAME____ RELATION TO PATIENT _________________________________

ALL PATIENTS MUST FILL OUT BELOW INFORMATION!

IF THE PATIENT IS 18 OR OVER, THE BELOW INFORMATION SHOULD BE FILLED OUT BASED ON THE PATIENT THEMSELVES.

OR

IF THE PATIENT IS UNDER 18 THE BELOW INFORMATION SHOULD BE FILLED OUT BASED ON THE PARENT PRESENT TODAY.

SOCIAL SECURITY NUMBER ________________________________ EMPLOYER ____________________________________
(**LAST 4 DIGITS** OF SSN REQUIRED FOR VERIFICATION OF YOUR IDENTITY WHEN CONTACTING OUR OFFICE)

WORK PHONE (_________)__________________________ SPOUSE'S NAME ____

PLEASE LIST THE NAMES OF ANYONE AUTHORIZED TO CALL REGARDING MEDICAL INFORMATION
*** IF LEFT BLANK WE WILL SPEAK ONLY TO THE PATIENT OR LEGAL GUARDIAN FILLING OUT THIS FORM ***

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INSURANCE INFORMATION: THIS SHOULD BE FILLED OUT BASED ON THE **POLICY HOLDER** OF THE INSURANCE POLICY
*** THIS INFORMATION WILL **NOT** BE FOUND ON YOUR INSURANCE CARD ***

POLICY HOLDER: CIRCLE: SELF / **OR** IF PATIENT IS NOT THE PRIMARY POLICY HOLDER FILL OUT BELOW:

PRIMARY INSURANCE
SUBSCRIBER NAME ______________________________
RELATION TO PATIENT ____________________________
SUBSCRIBER DOB ________________________________
SUBSCRIBER EMPLOYER ___________________________
SUBSCRIBER SSN (IF REQUIRED BY YOUR INSURANCE):
____

SECONDARY INSURANCE (IF APPLICABLE)
SUBSCRIBER NAME ______________________________
RELATION TO PATIENT ____________________________
SUBSCRIBER DOB ________________________________
SUBSCRIBER EMPLOYER ___________________________
SUBSCRIBER SSN (IF REQUIRED BY YOUR INSURANCE):
____

IF YOU WOULD LIKE A QUOTE OF YOUR INSURANCE BENEFITS AND ESTIMATED PAYMENT DUE, PLEASE SPEAK WITH THE FRONT OFFICE PRIOR TO BEING SEEN.

PLEASE REVIEW BEFORE SIGNING!

- **PAYMENT IN FULL IS DUE AT TIME OF SERVICE. WE HAVE VERIFIED ALL INSURANCE BENEFITS AND KNOW YOUR PORTION DUE AT CHECKOUT.**

- **WE WILL NOT BILL YOU FOR YOUR PATIENT RESPONSIBILITY. YOUR RESPONSIBILITY IN FULL IS DUE AT THE TIME OF YOUR VISIT.**

- **IF YOU NEED A QUOTE OF YOUR RESPONSIBILITY PLEASE ASK THE FRONT OFFICE STAFF PRIOR TO SEEING THE DR.**

LAB SERVICES: CLARA H. HENRY, M.D. USES COCKERELL & ASSOCIATES FOR ALL IN-OFFICE LABWORK. IF YOUR INSURANCE ALLOWS, THIS WILL BE AN IN-OFFICE CHARGE, TAKEN AT TIME OF SERVICE. SOME INSURANCE REQUIRES THE LAB DO BILLING, AND YOU WILL RECEIVE A BILL FROM COCKERELL & ASSOCIATES. IF ANY "SPECIAL STAINS" ARE PERFORMED ON THE SPECIMEN, THOSE WILL BE BILLED SEPARATELY IN ADDITION TO ANY AMOUNTS PAID.

REQUIRED INSURANCE INFORMATION: WE WILL NOT BACK-FILE YOUR INSURANCE. IF YOU DO NOT HAVE THE CORRECT INSURANCE INFORMATION AND/OR REFERRAL YOU WILL BE CONSIDERED A PRIVATE PAY PATIENT, AND NO REIMBURSEMENT WILL BE GIVEN SHOULD YOU CHOOSE TO FILE YOUR OWN INSURANCE AT A LATER DATE. IF YOU ARE IN YOUR GRACE PERIOD WITH YOUR INSURANCE, YOU WILL BE REQUIRED TO PAY IN FULL, REGARDLESS OF YOUR BENEFITS. IF YOUR INSURANCE MAKES PAYMENT, YOU WILL BE REFUNDED ONCE PAYMENT PROCESSES.

MOST INSURANCE COMPANIES DO NOT PAY FOR SURGICAL PROCEDURES DONE IN THE PHYSICIAN'S OFFICE. THIS INCLUDES REMOVAL OR TREATMENT OF LESIONS BY ANY METHOD. WE ARE CONSIDERED A SPECIALIST SO YOUR BENEFITS AT YOUR PRIMARY DOCTOR WILL NOT BE THE SAME HERE.

YOU WILL BE RESPONSIBLE FOR PROCEDURE CHARGES AT CHECK OUT.

BY SIGNING BELOW I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE PHYSICIAN FOR THE CHARGES INCURRED BY MYSELF AND/OR MY DEPENDENTS. I UNDERSTAND THAT IF THERE IS A DIFFERENCE BETWEEN THE AMOUNT I PAY AND THE AMOUNT DETERMINED BY MY INSURANCE COMPANY I WILL BE BILLED FOR THIS AMOUNT. IF PAYMENT IN FULL IS NOT RECEIVED WITHIN 30 DAYS OF MY INSURANCE DETERMINATION, I AM ULTIMATELY RESPONSIBLE FOR ALL AMOUNTS OWED AND MY ACCOUNT MAY BE SENT FOR FURTHER COLLECTIONS PROCEDURES AT THAT TIME. IF MY ACCOUNT IS SENT TO A COLLECTION AGENCY, I UNDERSTAND THAT I WILL ALSO BE RESPONSIBLE FOR THEIR FEES AS WELL. IF I AM UNABLE TO MAKE PAYMENT AFTER BEING SEEN TODAY, I UNDERSTAND THAT I MAY BE SENT TO COLLECTIONS IMMEDIATELY, WITHOUT A GRACE PERIOD FOR PAYMENT.

I HEREBY AUTHORIZE CLARA H. HENRY, M.D., P.A. TO RELEASE ANY INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN PROCESSING FOR FINANCIAL BENEFIT. I ALSO AUTHORIZE DIRECT BENEFITS TO CLARA H. HENRY, M.D., P.A. FOR SERVICES RENDERED. IF THE PATIENT LISTED ABOVE IS A MINOR OR IS INCAPABLE OF CONSENTING TO MEDICAL TREATMENT, I AM GIVING MY PERMISSION FOR SAID DEPENDENT TO RECEIVE MEDICAL CARE BY CLARA H. HENRY, M.D. I ALSO UNDERSTAND THAT AFTER THE FIRST VISIT, MINOR PATIENTS MAY COME WITHOUT ADULT SUPERVISION OR WITH ANOTHER CONSENTING ADULT UNLESS I NOTE OTHERWISE IN WRITING.

X____ ________________

Signature of Patient OR (Legal Guardian if under 18) Date

NOTICE OF PRIVACY PRACTICES Health Insurance Portability and Accountability Act of 2013 (HIPAA)
Please sign below, acknowledging that you have been given the opportunity to review our notice of privacy practices. Written copies of the current HIPAA policy are available for review upon your request.
Signing only confirms you have been given the opportunity to review HIPAA at your discretion.

X____ ________________

Signature of Patient OR (Legal Guardian if under 18) Date