

# CARE4ALL PLLC

Last Name:		First:	Middle:	Date Of Birth:	Social Security #:	
Billing Address:			Apt/Lot:	City:	State:	Zip:
Home Phone #:		Cell Phone #:		Preferred Method of Notification:		
				Home      Cell		
Sex:      Male _____ Female _____		Marital Status:    Single _____ Married _____    Widowed _____ Separated _____			Primary Language:	
Race: White _____    Black/African American _____ Asian _____    American Indian/Alaskan _____    Other _____				Ethnicity: Hispanic or Latino or Spanish Origin _____ Not Hispanic or Latino or Spanish Origin _____		
Maiden/Previous Legal Name:		Mother current and Maiden Name if Minor Patient:			Father's Name, if Minor Patient:	
Occupation of Patient:	Employer/ Company Name:		Employer Address:		Employer Phone #:	
Person to contact in Case of an Emergency:	Emergency contact Address:		Emergency contact Phone #:		Relationship to Patient:	
<b>Insurance Information</b>						
Primary Insurance:					Effective Date:	
Mailing Address:						
City:			State:		Zip:	
Subscriber's Name:			Subscriber's Employer:			
Policy #:			Group#:			
Secondary Insurance:					Effective Date:	
Mailing Address:						
City:			State:		Zip:	
Subscriber's Name:			Subscriber's Employer:			
Policy #:			Group#:			

Financial Agreement					
Responsible Party if Patient Under 18:			Relationship to Patient:		Responsible Party Social Security #:
Mailing Address:	APT/Lot	City:	State:	Zip:	Responsible Party Phone #:

### **Responsibility for Payment.**

As a patient/guarantor, I agree to be responsible for payment of services upon receipt of statement according to the following guidelines:

- If there is no health plan coverage or I elect to self-pay for medical services rendered, I will be responsible for payment at the time of service or I will establish payment arrangements with Care4All Pllc front desk.
- If my medical plan does not have a contracted arrangement with Care4All Pllc, I will assume full responsibility for my account balance not paid by my plan. This is often referred to as being "Out-Of-Network" or having an indemnity plan.
- If my health plan is contracted (participating) with Care4All Pllc, I agree to pay all applicable co-payments on date of service, as well as all deductibles, co-insurances and non-covered benefit charges.

### **Assignment of Insurance Benefits and Release of Information.**

I authorize payment from all applicable insurance carriers and payors directly to Care4All Pllc for the surgical and/or medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to physicians and/or other providers for services provided during my treatment. I understand and agree that I may be financially responsible to Care4All Pllc for charges not paid by my insurance policy and payors. I authorize Care4All Pllc to use and disclose my protected health information (PHI), including sensitive information related to mental health, substance abuse, HIV/AIDS, genetic testing, hospice care and other sensitive matters as needed for payment purposes. I permit a copy of this authorization to be used in place of the original.

Care4All Pllc will provide me with a copy of this form upon request.

\_\_\_\_\_  
Patient Signature/Guarantor

\_\_\_\_\_  
Insured's Signature (parent or Legal Reprehensive)

Date: \_\_\_\_\_

## **Consent:**

### ***Consent to treatment***

I consent to Care4All Pllc providing healthcare services and treatment to me. I consent to evaluation or treatment that the assigned healthcare provider may deem necessary. This may include diagnostic test, radiology and laboratory procedures, medication administration, taking and utilizing cultures, administration of anesthetics, HIV testing, and other necessary tests procedures and treatment. I understand that, except for emergency and extraordinary circumstances, certain procedures will not be performed without me being provided an opportunity to give inform consent for the procedures. I understand that I have the right to refuse consent to any proposed procedure or treatment at any time prior to its performance. I understand that this consent is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

*Initial here indicating that you have read the above statement.*

Patient or Patient Representative Initials. \_\_\_\_\_

### ***Photographs***

In the course of healthcare treatment, I agree that Care4All Pllc may take pictures and videos of me for identification, treatment, and other lawful purpose. Any pictures taken by Care4All Pllc while caring for me will be treated as part of my medical record and will be subject to applicable privacy law. Care4All Pllc will not take a picture of me in the course of my treatment for any other purpose, without my written permission.

Email Notification and Patient Portal

Email address: \_\_\_\_\_

If I have provided my email address on this form, or if I have signed up for the patient portal, I agree to receive electronic notification of announcement and information form Care4All Pllc, including but not limited to notice of privacy notices, and other information. I agree to update my contact information with Care4All Pllc as necessary or inform Care4All Pllc in writing if I no longer wish to receive emails.

*Initial here indicating that you have read the above statement.*

Patient or Patient Representative Initials. \_\_\_\_\_

# CARE4ALL PLLC

Signature: Care4All Pllc will provide me with a copy of this form upon request. I received and read a copy of Care4All Pllc HIPAA Notice of Privacy Practices (Notice). This consent applies to all of my PHI, even if Care4All Pllc obtained it before or after I signed this form. By signing below, I consent to and further authorize the use and release of my PHI as explained on this form and the Notice, as well as to my treatment, and to be contacted for the purpose described in the notice, including for treatment, hospital operation, accounting, billing, payment, collection, and possible treatment alternative and other health- related benefits and services that maybe of interest. *I certify that the Medical and Financial Information I provide to Care4All Pllc is true, Complete and Accurate in Every Respect.*

Patient/ Patient Representative Name (Please Print)

Date Signed:

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Signature:

Relationship to Patient (if not signed by patient)

Parent

Legal Guardian

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Other (explain authority) \_\_\_\_\_