2017 Soundview Medical Associates, LLC

PATIENT INFORMATION

Acct. Number:	**Date of Birth:**
Name:	**Social Security #:**
Address One:	**Sex:**
City:	**Ethnicity:** **Race:**
State: **Zip:**	**Email:**
Home (Primary)Phone#:	**Emergency Contact:**
Work (Tertiary)Phone#:	**Emergency Phone#:**
Cell (Secondary)Phone#:	**Emergency Relationship:**

GUARANTOR INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security#:**
Address Two:	
City:	**Employer:**
State: **Zip:**	**Employer Address:**
Home Phone#:	**Employer City:**
Work Phone#:	**Employer State:**
Cell Phone#:	**Zip:**

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Certificate#:	**Certificate#:**
Group Number:	**Group Number:**
Group Name:	**Group Name:**
Copay:	**Copay:**
Subscriber Name:	**Subscriber Name:**
Subscriber Date of Birth:	

Name of Relative Not Living with you:
Phone for above relative:
Preferred Method of Contact:

PLEASE HELP US HELP YOU

- Are you depressed or anxious? Yes ___ No ____
- Do you have difficulties obtaining transportation? Yes ___ No___
- Are you interested in creating a care plan with your Physician? Yes__ No_
- Are you aware we have a patient portal? Yes __ No__
- Do you feel safe at home? Yes___ No___ If not why_____
- Do you have any concerns about the safety of your living environment? Yes_ No_ If yes, why_____
- Are you interested in smoking cessation counseling Yes__ No___
- Are you interested in obesity counseling Yes___No___
- Are you aware SMA is a NCQA PCMH Level 3? Yes__ No__
- Have you signed our PCMH Partnership Agreement? Yes__ No__
- Do you have a Living Will or Advanced Directives documents? Yes__No__
- Have you designated a Durable POA or Health Care Agents? Yes__No__
  If you have, may we have copies of those documents?

TO PROTECT YOU AGAINST INSURANCE FRAUD WE REQUEST A COPY OF YOUR INSURANCE CARD(S) AND PHOTO ID.

- The use of cellular telephones is not permitted while on the premises.
- Soundview Medical Associates is happy to submit claims to your insurance company. Your co-pay is payable at the time of service as this is a contract between you and your insurance company. You may be asked to reschedule your appointment if you are unable to make your payment.
- Self-paying patients must pay at the time of service. We accept Visa, MasterCard, checks and cash.
- Soundview Medical Associates does not bill for third party claims. All Motor Vehicle and litigation claims must be paid at time of service.
- If your insurance company requires a referral to see a specialist, you will need to call 72 hours before your appointment in order for the referral to be processed.
- **If you need to cancel your appointment for any reason, you must give us 24 hours notice. If you do not give us 24 hours notice, you may be charged a cancellation fee of $50.00.**

I authorize the release of information necessary to determine the liability for payment and to obtain reimbursement on any claim. The assigned will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. I hereby authorize said assignee to release the benefits payable to which I am entitled, including Medicare, HMOs, private insurance, and other healthcare plans to Soundview Medical Associates.

I agree that the insurance information provided by me is true and correct. If this information is invalid, I agree to be fully responsible for payment. If my insurance carrier requires a referral for my visit and I do not obtain one, I will be responsible for payment. I further agree that if my physician does not participate with my insurance, I will be solely responsible for payment.

_____ _____

Patient Signature Date