Patient's Name: _____ Date: _____

Last First Middle

Home Address: _____

Zip Code: _____ City: _____ State: _____

List all phones and circle preferred:

Gender: Male / Female Home #: _____ Marital Status: _____

Title: Mr. Mrs. Ms. Work #: _____ Date of Birth: _____

Cell #: _____ S.S.#: _____

Email: _____ Employer: _____

Next of kin not living in home: _____

Name Address Phone Relationship

Primary Insurance: _____	**Secondary Insurance: _____**
Primary Insured's Name: _____	Secondary Insured's Name: _____
Insured's Address: _____	Insured's Address: _____
_____	_____
Home Phone: (_____) _____	Home Phone: (_____) _____
Work Phone: (_____) _____	Work Phone: (_____) _____
Cell Phone: (_____)_____	Cell Phone: (_____)_____
Email: _____	Email: _____
Employer: _____	Employer: _____
Gender: M / F Date of Birth: _____	Gender: M / F Date of Birth: _____
Title: Mr. Mrs. Ms. S.S.# _____	Title: Mr. Mrs. Ms. S.S.# _____

Full Name and # of Primary Physician: _____

AUTHORIZATION:

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to :* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. * Obtain payment from third-party payers. * Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of *the Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Payment is due at the time of service. Members of participating insurance plans are responsible for deductibles and co-payments. I understand that I am financially responsible for all charges, whether or not covered by insurance. The Responsible Party will be held liable when furnishing fraudulent insurance information, incorrect address or billing information. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Jacquelyn B. Garrett for services furnished to me by her. I will give 24 hours notice if I am unable to keep an appointment to avoid a **$50.00 charge**. Failure to keep appointments twice without 24 hours notice will result in termination of care by this office. If the services of a Collection Agency/Agent are employed to collect an outstanding balance, I agree to pay any and all reasonable costs incurred. I also agree to pay a service charge of **$30 for non-payment of checks.**

SIGNATURE of Responsible Party:_____Date_____

Relationship to Patient_____