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:

Insurance Information

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#:	

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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: _____

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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._____

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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:

_____

Signature:

_____

Relationship to Patient (if not signed by patient)

Parent Legal Guardian

Other (explain authority) _____

New Patient medical history.

Name: _____ Date of Birth: _____

Please mark each of the following that applies to you. (Current or Past)

Cardiovascular	Yes	No	Respiratory	Yes	No	Gastrointestinal	Yes	No
Aneurysm			Asthma			Cirrhosis		
Angina			Bronchitis			GERD		
DVT			COPD-Bronchitis/Emphysema			Gallbladder		
Dysrhythmia			Pleuritis			Heartburn		
HTN			Pneumonia			Hemorrhoids		
Murmur						Hepatitis		
Myocardial Infarction			**Musculoskeletal**			Hiatal hernia		
Other Heart Disease			Arthritis			Jaundice		
			Gout			Ulcer		
Genitourinary			M/S injury					
Hernia						**Skin**		
Incontinence			**Neurological**			Dermatitis		
Nephrolithiasis			Epilepsy			Mole(s)		
Other Kidney disease			Syncope			Other Skin Condition		
STD			Severe headaches/Migraines			Psoriasis		
UTI			Stroke					
			TIA			**Endocrine**		
Psychiatric						Goiter		
Bipolar disorder			**Heme/Onc**			Hyperlipidemia		
Depression			Anemia			Thyroid disease		
Hallucination, delusion			Cancer			Type I DM		
Suicidal Ideation						Type II DM		
Suicide Attempts			**Infection**					
Dementia			HIV					
			Tuberculosis					

Other Medical problems not listed above?

_____

_____

_____

Allergies- Please describe any allergic reactions to medication, foods, and or environment.

_____

_____

_____

Medication List Currently Taken.

Medication name	Dosage	How Often	Purpose

Past Surgical History.

Family History. Mothers Side Fathers side

	Mother	Grandmother	Grandfather	Father	Grandmother	Grandfather
Alive						
Deceased						
No Health Concern						
Arthritis						
Asthma						
Bleeding Disorder						
CAD >age 55						
COPD						
Diabetes						
Heart Attack						
Heart Disease						
High Cholesterol						
Hypertension						

Mental Illness						
Osteoporosis						
Stroke						
Breast Cancer						
Colon Cancer						
Ovarian Cancer						
Prostate Cancer						
Uterine Cancer						

Other family history that is not listed above.

_____

_____

_____