Patient Information

- Account/Chart #: _____
- Preferred Name_____
- Full Name: _____
- Email: _____
- Address: _____
- Home/ Cell Phone #: _____
- Social Sec #: _____
- Date of Birth: _____
- Marital Status: _____
- Sex: _____

Insurance Holder Information

Primary Insurance

- Subscriber Name: _____
- Date of Birth: _____
- Home/Cell Phone #: _____
- Social Sec#: _____
- Relationship to Patient: _____

Secondary Insurance

- Subscriber Name: _____
- Date of Birth: _____
- Relationship to Patient: _____

Person Responsible for Bill

- Responsible Party Name: _____
- Address: _____
- Home/Cell Phone #: _____

Emergency Contact

- Contact Name: _____
- Relationship to Patient: _____
- Home/ Cell Phone #: _____

Authorization: Signature: _____ Date: _____

PATIENT AUTHORIZATION

I authorize Mesa Family Practice to release information from the patient's medical records, including providing copies of medical records, which may be necessary or appropriate for any third party payor (insurance company, government agency, etc.) to determine if it is obligated to make any reimbursement or payment for any or all of patient's charges. I hereby release Mesa Family Practice, its agents and all attending physicians from any and all liability for the furnishing of such information. I understand and agree that Mesa Family Practice is not responsible for the confidentiality of information provided to third party payors pursuant to this authorization and that Mesa Family Practice is entitled to rely upon requests by third party payors in determining that the information requested is appropriately requested.

I understand there is no guarantee of reimbursement or payment from any insurance company or third party payor and that I am financially responsible for all charges incurred on behalf of the patient. Should a group health plan of which I am a member decide that a service provided to me or my dependent as not a covered expense, I acknowledge that I shall be responsible for the payment for that service.

X_____ _____

SIGNATURE OF PATIENT/GUARDIAN DATE

PATIENT AUTHORIZATION

I understand that I am financially responsible for all charges incurred on behalf of the patient. I acknowledge that I shall be responsible for the payment for all services rendered at Mesa Family Practice. I further understand that payment in full is expected on the date of service unless payment arrangements are made in advance.

X_____ _____

SIGNATURE OF PATIENT/GUARDIAN DATE

ACKNOWLEDGEMENT OF RECEIPT OF HIPPA PRIVACY PRACTICES NOTICE

I have reviewed the Privacy Practices Notice for Mesa Family Practice, published and effective April 14, 2003. I understand I may be given a copy of this notice at any time upon my request and that this document is subject to modifications outlined in the notice.

_____

Printed Name of Patient

X_____ _____

Patient Signature Date

_____

Relationship to Patient

X_____

Witness Signature

MESA FAMILY PRACTICE

2130-A Farmington Ave.
Farmington, NM 87401
Telephone: (505) 325-2323
Fax: (505) 325-7172

I, _____, give Mesa Family Practice permission to release any and all medical information (including billing and scheduling) pertaining to me, to the following person(s):

Name	Phone #	Relation to patient
Name	Phone #	Relation to patient
Name	Phone #	Relation to patient
Name	Phone #	Relation to patient

Patient Signature **Date**

MESA FAMILY PRACTICE

Notice to Patients

No-Show policy

Appointments at Mesa Family Practice are in high demand and often difficult to obtain on short notice, therefore Mesa Family Practice has implemented a No-Show Policy to best serve the needs of all our patients.

Appointment times are scheduled to allow us to take care of each individual patient's needs during the patient's visit; therefore, we now require advance notice from our patients who are unable to keep their scheduled appointments.

Please read each statement and **initial** to show that you have read and understand the No-Show Policy:

_____ Failure to show-up for a scheduled appointment time, without notice of cancellation, will be considered a No-Show.

_____ Failure to cancel an appointment by 3:00 pm, one business day prior to the scheduled appointment time (late cancellation), will be considered a No-Show.

_____ Failure to arrive on time for a scheduled appointment time (late show) and unable to be seen by provider will be considered a No-Show.

_____ Every No-Show will result in a No-Show Fee of $40. This fee will be added to the patient chart and is required to be paid prior to scheduling another appointment.

_____ New Patients appointments will be charged a $100 fee for a No-Show appointment and will not be able to schedule another New Patient appointment until the fee has been paid in full.

By signing below, I acknowledge that I have read and understand the statements above.

Date: _____

Signature: _____ Printed Name: _____

Signature of Parent /Guardian if Patient Under 18: _____

==========

For use if patient declines to sign:

☐Patient (Name) _____ has refused to sign above and understands that if they No-Show an appointment at Mesa Family Practice, we reserve the right to discharge them from the practice.

Witnessed by _____