EMERALD WATERS MEDICAL CLINIC

1005 College Blvd West, Suite B, Niceville, FL 32578-1060
Telephone: (850) 279-6815/Fax: (850) 279-6817

PATIENT INTAKE QUESTIONNAIRE

(We do not discriminate based on race, creed, sex or disability)

All questions contained in this questionnaire are strictly confidential and in addition, will become part of your medical record.

PATIENT INFORMATION:

SS#___________________________________ Today's Date:________________________

Name: Last_____________________________________First________________________________MI__________

Address:______________________________City:__________________________State/Zip Code: ______________

Date of Birth: ____________________________Age :_________________ Sex: ___________M______________F

Home Ph:________________Cell:__________________Work:______________Email:__________________________

Marital Status: ___Single ___Partnered ____Married ____Widowed Primary Spoken Languages:__________________

Race: _____ Blk _____ Wht ______ Asian _____Native American ____Other // Ethnicity: ____Hispanic ___ Non-Hispanic

Emergency Contact: Name: Last___________________________________ First ______________________________
Home Ph:__________________________Cell:_______________________Work:_____________________________

FINANCIAL RESPONSIBILITY:

Name: Last_____________________________________First_______________________________________MI_________
Address:_____________________________________City:____________________________State/Zip Code ___________
Home Ph:____________________Cell:________________Work:_______________Email Address_____________________
Employer's Name:____________________________________Address:____
Income: $_________________Per: Week__________Bi-Weekly__________Montly_____________Yearly______________

INSURANCE COMPANY:

Primary Insurance:______________________________ID#________________________Group#_______________________
Insurance Co Address:____
Name of Insured: Last: ______________________First:__________________ Date of Birth of Insured:_____________________
Patient Relationship to Insured: ____Self ____Spouse ____ Child ____ Parent
Secondary Insurance:_______________________________ID#________________________Group#_____________________
Insurance Co Address:____
Name of Insured: Last: ______________________First:__________________ Date of Birth of Insured:_____________________
Patient Relationship to Insured: _______Self _________Spouse _________ Life Partner__________Child _______________ Parent
Medicaid #_______________________________________ **Medicare #**____

Assignment and Release: I authorize my insurance benefits to be paid directly to Emerald Waters Medical Clinic. I also authorized Emerald Waters Medical Clinic to release any information required to process my claim(s).

____ ___________________________

Patient's Signature/Legal Guardian/Auth Representative **Date**

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Thank you for choosing **Emerald Waters Medical Clinic**. The following is our financial policy and we request that you read, and sign that you understand the contents of this page prior to treatment in our clinic.

Insurance: Your insurance policy is between you and your insurance company. As a service to our patients, we will make every effort to obtain a summary of your insurance policy and if required assist in obtaining an authorization for you, but you may not be able to be seen prior to the authorization being obtained. We do accept assignment of benefits from insurance companies with which we are participating providers as well as those who have out of network benefits however, If services are not covered by your insurance policy, you will be responsible for all fees assigned by our clinic.

Payment: All payments to include; co-pays, or deductibles are due prior to receiving services. Payments can be made by cash, money order, debt and credit card payments (MasterCard, Visa, or Discover). If a balance is outstanding on your account then routine care may be interrupted until a payment arrangements for any outstanding balances are made. Severe and outstanding account balances will be forwarded to our collection agency after 90 days **Initial______.**

Insurance Patients: My insurance requires that I pay a deductible of $_____________. After my deductible is met, my responsibility is $_____________ copay/ or ______________% co-insurance as outlined in my policy.

Cash Pay Patients: Generally will be subject to usual and customary fees scale and all fees will be disclosed to you prior to your medical care or treatment in our clinic: My Initial Visit Fees: $________Follow-Up Fees: $_________. **Initial____.**

Discounted/ Patients: I understand that based on my total household income and dependents listed on my/spouse or partner IRS Tax Return filed by April 15th each year; or review of substantial proof of my total household income and dependents listed on copies of 3 months of pay check/W2 forms for me, my spouse or partner that; I am qualified for a discounted sliding fee scale of $___________ and I will be required to updated this information each year that I am on a discounted fee scale by the above stated date. **I also understand that failure to bring in the required documents will result in the assignment of Emerald Waters Medical Clinic (usual and customary fee scale, no exceptions). Initial**____.

Appointment Cancellation Policy: Emerald Waters Medical Clinic is committed to our patients and continues to accept new patients. A missed appointment is a missed opportunity and delay in care for another patient therefore, if for any reason you are unable to keep your appointment, please call our office at least two (2) hours in advance to allows us to schedule another patient in your time slot, otherwise you will be charged a $25 cancellation/no show fee. I**nitial_____.**

By signing this document below I do acknowledges that I have read, fully understand, and agree to all parts of the financial policy that pertain to my financial circumstance for Emerald Waters Medical Clinic. I also understand that a copy of this financial policy is available upon request for my records and I will make the office staff aware if I have any questions or concerns pertaining to this financial policy.

Signature of Patient:____ Date_________________________

Signature of Parent/Guardian:____ Date_________________________

Witness if Required:____ Date_________________________

Updated Feb/2015-mds: Intake form 02