
Demographic Sheet

Patient printed name:

First _____

Middle _____

Last _____

Preferred name: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Date of birth: _____

SS#: _____

Marital status: _____

Employment Status: _____

Sex: _____ Preferred sex: _____ Race: _____

Ethnicity: _____ Language: _____

Patient Signature: _____ Date: _____

Sign up for our NEW Patient Portal by giving us your EMAIL ADDRESS

- Review your lab reports
- Request and receive prescriptions
- Keep track of past and future appointments

The screenshot shows the sign-up page for the Health Care Institute of North Florida Patient Portal. At the top right, there is a 'Sign in' section with a 'User Name' field, a 'Password' field, and a 'Login' button. Below this is a link for 'Can't access your account?'. The main content area features the HCI logo on the left and the text 'The Health Care Institute of North Florida' followed by a description: 'HealthCare Support Portal facilitates better communication with your physician's office by providing convenient 24 x 7 access from the comfort and privacy of your own home or office.' Below this, a grey bar states 'Using your secure portal you will be able to:'. Three icons represent the portal's features: 'Lab Reports' (a clipboard with a red line graph), 'Appointments' (a calendar with a pen), and 'Request Refills from your doctor' (a pill bottle and pills). To the right of these icons is a large image of a computer monitor displaying the portal's interface. At the bottom, a blue footer contains the copyright notice: 'Copyright ©2015 eClinicalWorks. All rights reserved. version 6.2. Use of this website constitutes acceptance of our Terms Of Use and Privacy Policy.'

Name: _____

Email: _____

Cell Phone: _____



HEALTH CARE INSTITUTE
OF NORTH FLORIDA

HEALTHCARE INSTITUTE OF NORTH FLORIDA
RICHARD L. WRIGHT, MD, RPVI



VEIN CARE INSTITUTE
OF NORTH FLORIDA

AGREEMENT TO PAY/INSURANCE RELEASE FORM

Patient Name: _____ DOB: _____

Responsible Party Name: _____ Relationship: _____

Thank you for choosing The Healthcare Institute as your provider of services. We appreciate the opportunity and privilege of participating in your care. With respect to payment of services, please review the following policies.

- Fees are charges for the professional services rendered. You, as the responsible party, accept complete financial responsibility for payment of all services provided.
- You are expected to pay all deductions, co-pays, co-insurance amounts, and non-covered services at the time of service. If you have a high deductible plan (\$1000 or more) you are required to pay for services at the time of service until the deductible is met. HCI will bill your insurance company for all covered services.
- You are financially responsible for any non-covered services performed during a physical exam.
- You are financially responsible for payment in full for any services that are denied as a non-covered service, not medically necessary, or if you failed to notify us of changes in insurance coverage, or if you did not obtain a referral or authorization as required by your insurance.
- You are responsible for notifying HCI immediately of any changes in your insurance policy and for obtaining insurance related referrals and/or authorizations.
- If payment on a submitted claim is not received from your insurance within 90 days, you are responsible for payment of the balance in full at the time. If your insurance company makes payment after the 90 days, you will be issued a credit within 30 days of payment.
- If HCI is a non-participating provider (out of network) with your insurance company, you are responsible for payment in full at the time of service. We will submit a claim to your insurance company on your behalf. If your insurance company makes a payment on the claim, you will be issued a credit.
- HCI may release patient information to third party payers and anyone assisting us in obtaining payment, including billing, coding, and collection agents and to the providers attorneys and consultants.
- HCI reserves the right to discontinue services if you do not pay outstanding balances.
- I understand that HCI cannot guarantee payment from participating insurance providers for service. Therefore, if my insurance carrier denies payment, I agree to be fully responsible for payment.
- I request that payment under my third party payer(s) be made directly to HCI and I authorize them to submit claims to payers on my behalf. I understand that I agree to HCI's policies as stated here.

Responsible Party Signature: _____ Date: _____

The Health Care Institute

I authorize the following person(s) to **pick up medical records, prescriptions, etc.**

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

I authorize the following person(s) to **discuss medical, financial and insurance information.**

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Emergency Contacts

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____