DEMOGRAPHIC SHEET

Patient Printed Name:

First: _____

Middle: _____

Last: _____

Preferred Name: _____

Date of Birth: ____ / ____ / ____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **SSN:** _____

Marital Status: _____

Employment Status: _____

Sex: _____ **Preferred Sex:** _____ **Race:** _____

Ethnicity: _____ **Preferred Language:** _____

Patient Signature: _____ **Date:** ____ / ____ / ____

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 deductibles, 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:** ____/____/____

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

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:** _____

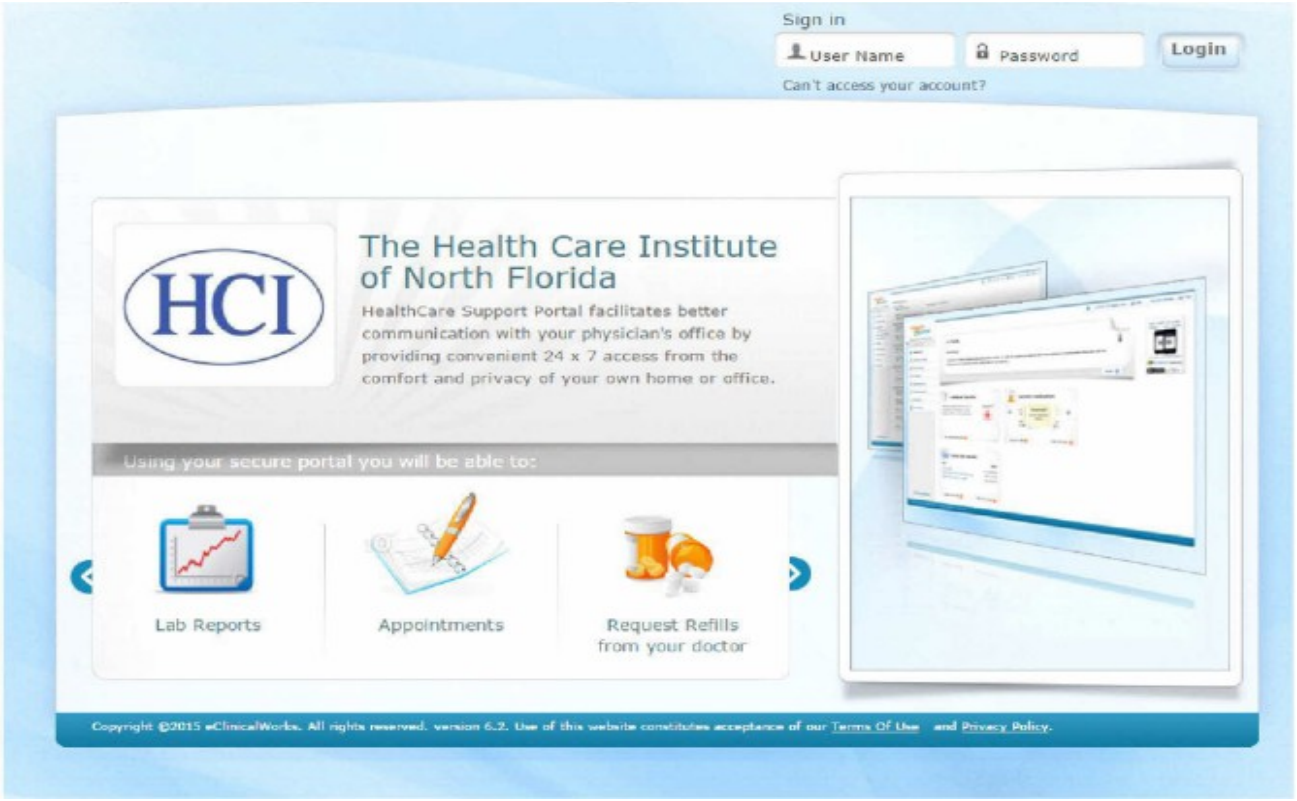
Name: _____ **Relation:** _____ **Phone:** _____

Name: _____ **Relation:** _____ **Phone:** _____

Signature: _____ **Print:** _____ **Date:** ____/____/____

PATIENT PORTAL

- Review Lab Reports
- Request and receive prescriptions
- Keep track of past and future appointments



Sign-up for Patient Portal by giving us the following information:

Name: _____

Email: _____

Phone: _____ / _____ / _____