HealthMotivate Care

Patient Name:_____ Age:_____ Date of Birth:_____

Marital Status:_____ Social Security #:_____ □ Male □ Female

Mailing Address:_____ City/State:_____ Zip:_____

Home Phone: ( )_____ May we contact you at work? □ Yes □ No

Cell Phone: ( )_____

Work Phone: ( )_____ Employer:_____

Email: _____

Emergency Contact:_____Phone:_____ Relationship to Patient: _____

Pharmacy (please specify location if more than one): _____

How did you hear about us? Please circle: Internet Phone book Friend or Family Other :_____

How would you like to be contacted? Please circle: Home Phone Cell Phone Work Phone Email Letter

Which race do you feel best describes you? Please circle: White Black or African American American Indian or Alaska Native

Native Hawaiian or other Pacific Islands Asian Prefer not to disclose Other: _____

Do you consider yourself Hispanic? Please circle: Yes No Not sure Prefer not to disclose

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If not the patient, who is the Guardian or Responsible Party?:

Name:_____ Relationship to Patient:_____

Social Security #_____Address:_____

City/State:_____ Zip:_____ Home Phone: ( )_____

Employer:_____ Address:_____

City/State:_____ Zip:_____ Work Phone: ( )_____

To the best of my knowledge, the information above is true and complete. I understand that I am responsible to pay for all services rendered to me, and that I am willing to make specific arrangements to pay whatever part is not covered by insurance on a timely basis. If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. I hereby assign all medical benefits to which I am entitled to my physician for services rendered to my dependent or me. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

PATIENT/GUARDIAN SIGNATURE:_____ **DATE:**_____

MEDICARE ASSIGMENT/SIGNATURE ON FILE:
I request that payment of authorized Medicare benefits be made either to me, or on my behalf to HealthMotivate Care for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to the Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration, and its agents, any information needed to determine these benefits, or the benefits payable for related services.

SIGNATURE:_____ **DATE:**_____