

# Pisgah Family Health, P.A.

Please PRINT

➤ **Patient Last Name** \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_ - \_\_\_\_\_  
Phone (Home) \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Marital Status:  Married  Single  Widow  Divorced  
SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License No \_\_\_\_\_ ST \_\_\_\_\_  
Email \_\_\_\_\_ Cell Phone \_\_\_\_\_  
  
Employer Name \_\_\_\_\_  
Phone (Work) \_\_\_\_\_ Occupation \_\_\_\_\_

➤ **Person Responsible for the Bill:**  Self\*  Spouse  Parent  Other  
\*If self, you do not need to complete this area again, please sign state  
Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_ - \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ Gender:  M  F  
SSN: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Employer Name \_\_\_\_\_ Phone (Work) \_\_\_\_\_

\*I understand that I am financially responsible for my charges with Dr Curran.  
Signature \_\_\_\_\_

➤ **Patient Insurance:** Please give insurance card(s) to receptionist when forms are complete  
 Medicare  Medicaid  Cash pay  Insurance Co-pay \$ \_\_\_\_\_

➤ **How did you learn of Pisgah Family Health, PA?**  
 Yellow Pages  Yellow Book  MD referral \_\_\_\_\_  
 Patient or family member  ER/ProMed  Employee referral  Insurance Co  
 First Impressions  Welcome Newcomer  Direct Mailing  Other \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- < Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- < Obtain payment from third-party payers.
- < Conduct normal healthcare operations such as quality assessments and physician certifications.

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name or Legal Guardian: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_