Blue Horizon Medical Clinic L.L.C

Sharon Blue ARNP-C, MSN

Today's Date: __________

Patient Information

First Name		Middle Name		Last Name	
Sex : M F	Marital Status		Date of Birth:	Social Security #	
Patient address			City	State	Zip
Home Phone	Cell phone:		Work number:	Ok to call at work? Y N	

Please indicate if it is okay for us to leave a confidential voice mail that may include test results, prescription information, or any other medical information pertaining to your health. This will reduce the need for you to return our call if you do not have any additional questions. This should be a phone number where only you, or anyone that you are comfortable with hearing your medical information has access to.

Phone number that it is ok to leave message on	Initials:

Ethnicity	Race	Preferred Language
Occupation	Employer	How Did You Hear About Us?
Preferred Pharmacy	Pharmacy Cross Streets	Pharmacy Phone Number

How May We Contact You?
Please Select All That Apply Mail ☐ Text ☐ Email ☐ Phone ☐

Email Address	Phone Number we can text to

Please send me an email invitation to register for the Blue Horizon Medic Clinic L.L.C. The portal can be used to request appointment's, for medication refill requests and for non emergent medical questions.

Initial______________

Parent/Guardian/Spouse/Domestic Partner

First Name	Middle Name	Last Name	
Sex	Marital Status	Date of birth	SS #

Address	City, State	Zip Code

Home Phone	Cell Phone	Work Phone Ok to call at work Y N

Insurance Company Information

Insurance Company Name	ID #	Group #
Street Address	City, State, Zip	Phone #
Name of Subscriber,(MUST HAVE name, SSN, DOB to bill)	Social Security #	Subscriber's Date of Birth

Work Comp and Auto Insurance Only

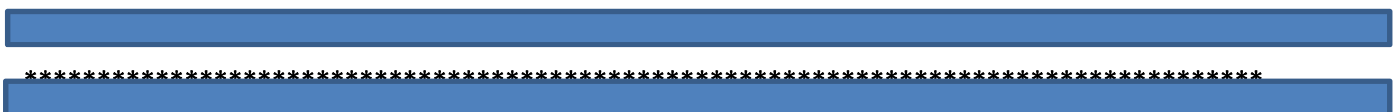
Name of Workman's comp or Auto Insurance company	Date of Accident:	Claim's Adjuster Name:

Secondary Medical Insurance

Secondary Insurance Name	ID#	Group #
Street Address	City, State, Zip	Phone #
Name of Policy Holder	Social Security #	Date of Birth

Emergency Contact Information

Name	Relationship	Phone #
Address	City State	Zip



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AGREEMENT TO PAY FOR TREATMENT

I, the responsible party, hereby agree to pay all the charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization, with which this office had a contractual agreement , I agree to pay all applicable co-payments, co-insurance and deductibles, and appointment cancelation fees which arise during the course of treatment for the patient. The responsible party also agrees to pay for treatment rendered to the patient, which is not considered to be a covered service by my insurer and/or a third party insurer or other payor. I further

understand that if I do not show for an appointment or do not give 24 hour's notice to Arbor Family Medicine, PC when canceling an appointment I may be
responsible for the charges up to the potential cost of the visit.

X____ **RESPONSIBLE PARTY**
DATE

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER

I, hereby authorize Blue Medical Group, L.L.C. and its employees to release and disclose, all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I, authorize the release and disclosure of any and all of my, or my child's, medical records to any other entity, including, but not limited to specialty physicians, hospitals, or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient. I, authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled. I, authorize this office and/or its employees to release, via fax or other secure electronic means, medical records which are needed in order to provide the patient with the most appropriate medical care.

I, authorize and request that payment of any third party or insurance company benefits be made directly to Arbor Family Medicine, PC for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

X____ **RESPONSIBLE PARTY**
DATE

CONSENT FOR TREATMENT

By signing below, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medical services, surgical or diagnostic procedures, including lab and radiographic studies, as ordered by this office and it's healthcare providers.

X____
RESPONSIBLE PARTY **DATE**

***Patients with Health Plans, please present your insurance ID Card to the receptionist after completing this form.**

***Some contract Health Plans (HMO, PPO, IPA, etc) require a co-payment at the time of service-Please have this ready prior to your visit as well as any current balance due. If copay or past due balance is not paid at the time of visit, patient may be required to reschedule the appointment.**

***Patient is responsible for all lab work and must be prepared to tell the BHMC staff which lab their insurance requires them to use. If presenting new insurance on the day that labs are drawn, the patient should inform the patient person drawing their labs. BHMC will not be able to make changes to the lab company once the lab leaves our office for processing.**