

Charles J. DePaolo, M.D., P.A.

3B McDowell Street, Asheville, NC 28801 • Phone 828-225-1920 • Fax 828-225-1924

Account # _____ Appt. Date: _____ Appt. Time: _____

PATIENT INFORMATION

Patient SSN: _____ Pharmacy Preference and location: _____

Patient Name: _____

Patient Address: _____
(Street Address) (City, State, Zip Code)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: Male Female Birth date: _____ Marital Status: S M D W

Patient's Employers: _____ Work Phone: _____

Employer Address: _____
(Street Address) (City, State, Zip Code)

Referring Doctor: _____ Primary Care Doctor: _____

Guarantor Name: _____ Guarantor Phone: _____

Guarantor Address: _____
(Street Address) (City, State, Zip Code)

IS THIS APPOINTMENT IN RESPONSE TO A WORK-RELATED INJURY?

If NO, please complete the insurance information below. If YES, please complete the additional Patient Information Form.

INSURANCE INFORMATION

PRIMARY Insurance Company: _____

Insurance Address: _____
(Street Address) (City, State, Zip Code)

Subscriber's Name: _____ Subscriber's Sex: Male Female

Subscriber's SSN: _____ Subscriber's Birth date: _____

Relationship to Patient: self spouse parent

Subscriber's Employer: _____ ID Number: _____ Group Number: _____

SECONDARY Insurance Company: _____

Insurance Address: _____
(Street Address) (City, State, Zip Code)

Subscriber's Name: _____ Subscriber's Sex: Male Female

Subscriber's SSN: _____ Subscriber's Birth date: _____

Relationship to Patient: self spouse parent

Subscriber's Employer: _____ ID Number: _____ Group Number: _____

CONSENT SECTION:

I consent to medical treatment and procedures by Charles J. DePaolo, MD, PA and his staff and have read and agree to the policy sheet included in the new patient package. I am responsible for all charges incurred at Charles J. DePaolo, MD, PA and authorize payment of insurance benefits (Medicare, Medicaid, or commercial insurance) directly to this practice. I authorize the release and transmission of pertinent medical information for research purposes and/ or medical information necessary to determine insurance benefits. I am responsible for payment of all charges not covered by insurance contracts, including co-payments, deductibles, non-covered services, and those determined by the insurance company, where there is no contract with Charles J. DePaolo, MD, PA to be above their usual and customary.

Authorization for the Use and Disclosure of Individually Identifiable Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. Please the family members or other persons, if any, whom we may inform about your appointments, labs, x-ray results and/ or other healthcare information. **PLEASE NOTE THAT THE FIRST PERSON LISTED SHOULD ALSO BE YOUR EMERGENCY CONTACT.**

NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____

Can confidential messages including appointment reminders, labs, x-ray results, and/ or other health care information be left on your home answering machine or voicemail? (PLEASE CHECK ONE) YES NO

IF NO, PLEASE PRINT THE TELEPHONE NUMBER, IF ANY, WHERE YOU WANT TO RECEIVE THIS INFORMATION: _____

I understand that I may revoke or change this authorization at any time by notifying the office of Charles J. DePaolo, MD, PA in writing. I understand and agree that Charles J. DePaolo, MD, PA has THIRTY (30) days from the receipt of the written revocation to update this information in the system.

However, the revocation will not be valid if:

1. Charles J. DePaolo, MD, PA has taken action in reliance on the above authorization.
2. This authorization is obtained as a condition for obtaining insurance coverage. Other laws provide the insurer with the right to contest a claim under the policy or the policy itself.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I have received a copy of the Notice of Privacy Practice for the above named practice. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by writing to the Privacy Officer, 3B McDowell Street, Asheville, NC 28801 or by requesting one in person at the office located at the same address.

Patient Signature: _____

Date Signed: _____