

**Gahanna Family Practice, Inc.**  
4550 N. Hamilton Rd., Gahanna, Ohio 43230  
(614) 428-8200 ~ fax (614) 428-9700  
drlake@gahannafp.com ~ www.GahannaFP.com

## Patient Information Form

Date: \_\_\_/\_\_\_/\_\_\_ Doctor: \_\_\_\_\_ Acct. No: \_\_\_\_\_  
If new patient, referred by: \_\_\_\_\_

Patient's Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_  
(Last) (First) (M.I.)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Ext: \_\_\_\_\_

Cell #: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Hours: \_\_\_\_\_

Male  Female Employer/School: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status:  Single  Married Spouse's Name: \_\_\_\_\_ Spouse's DOB: \_\_\_/\_\_\_/\_\_\_

Name(s) and DOB(s) of family members who live with you that are patients here: \_\_\_\_\_,  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

**Primary Insurance Company:** \_\_\_\_\_ SSN of Policy Holder: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Co-payment: \$ \_\_\_\_\_

### The following will be in effect until any written changes are provided by patient/responsible party:

May we leave detailed information on your answering machine or voicemail concerning referrals or appointments?  Yes  No

May we leave detailed information with other residents at your home concerning referrals or appointments?  Yes  No

If you are unavailable, is it okay for our automated "Housecalls" system to leave appointment reminders at your home?  Yes  No

To whom may we give laboratory or test results? Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Whom do you give authorization to pick up medical information for you, such as prescriptions, samples, X-rays, and other paperwork, from our office? \_\_\_\_\_ and \_\_\_\_\_

**\*\*More extensive authorization for us to discuss or release your medical information requires a separate authorization form.\*\***

In case of an emergency and if unable to communicate with the office due to illness, list a family member whom we may contact:

\_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Person not living with you that we may contact for non-emergency issues:

\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Email address for communication of non-emergency issues (optional): \_\_\_\_\_

I hereby give my consent for Gahanna Family Practice to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care options (TPO). (The Notice of Privacy Practices provided by Gahanna Family Practice describes such uses and disclosures more completely) I have the right to review the Notice of Privacy Practices prior to signing the consent. Gahanna Family Practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Gahanna Family Practice, Attention Privacy Officer. With this consent, Gahanna Family Practice may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others. I have the right to request that Gahanna Family Practice restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions.

By signing below I am giving Consent for Treatment and Acknowledgement and Receipt of Privacy Notice:

**Patient (Responsible Party) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

For office use only: **Amicore** \_\_\_\_\_ **Med Mgr** \_\_\_\_\_

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## Payment Policy

**Patient Name (please print):** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. This payment policy explains your financial responsibilities. Please read it, let us know if you have any questions, and sign below.

**1 Insurance.** We participate in most insurance plans. If your insurance changes, please notify us immediately so we can make the appropriate changes to help you receive your maximum benefits. If your insurance does not pay your claim within 45 days, the balance will be your responsibility. Knowing your insurance benefits is your responsibility; please contact your insurance company with any questions you may have regarding your coverage.

**\* I request that payment of authorized Medicare and/or other insurance company benefits be made to Gahanna Family Practice, Inc. on my behalf for any services furnished me by Gahanna Family Practice. I authorize any holder of medical information about me to release any information needed to determine those benefits or to pay for related services.**

**2 Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Please help us by paying your co-payment at each visit.

**3 Non-covered services.** Please be aware that some—and perhaps all—of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You would be responsible to pay balance in full.

**4 Claim submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

**5 Self Pay.** Self pay patients are required to pay 100% fee for service at time of visit.

**6 Nonpayment.** If your account is over 60 days past due, you will receive a letter stating you have 60 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collections agency and you and your immediate family will be discharged from the practice. We would notify you by certified mail and provide emergency care during the next 30 days while you find alternative medical care.

**7 Missed appointments.** It is important to notify us if you are unable to keep an appointment. Our policy is to charge for missed appointments that are not cancelled the day before the appointment time. These charges will be your responsibility and billed directly to you. Help us serve you better by keeping your scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges in our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

**Patient (Responsible Party) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_