Patricia K. Brougher, MD, PA
PATIENT INFORMATION FORM

Demographics (Complete in full):

Today's Date _____

Name _____ Age_____ Date of Birth_____

Address_____ HM Ph # _____

City _____ State_____ Zip _____ Cell Ph# _____

SSN _____ Single_ Separated_ Married_ Divorced_ Wk Ph# _____

Race: _____ Ethnicity _____ Gender _____

Preferred Communication: _____ Primary Language: _____

E-mail address: _____ **(necessary for appt confirmation)**

Employment Information:

Employer's Name_____ Occupation_____

Address: _____ City_____ State: ____ Zip_____

Employer's Telephone ( ) _____ Ext: _____

Emergency Contact Information:

Name_____ Telephone ( ) _____ Relation_____

Name_____ Telephone ( ) _____ Relation_____

PREFERRED PHARMACY: _____**Telephone** ( ) _____

Reason for consultation: _____

List **any allergies** to medication: _____

Insurance Information:

Primary Insurance Name _____ Insured SS#: _____

Name of Insured _____ Insured's Date of Birth _____

Employer's Name_____ Employer's Telephone ( ) _____

Secondary Insurance Name_____ Insured SS#: _____

Name of Insured _____ Insured's Date of Birth _____

Employer's Name _____ Employer's Telephone ( ) _____

Signature below is only acknowledgment that you have received the **Notice of our Privacy Practices**

Patient Name: _____ Signature: _____ Date: _____

Assignment of Benefits

I, the undersigned, understand that I am financially responsible for all charges whether or not my insurance pays.
I hereby authorize the release of all information necessary to secure payment.
I hereby assign all Medical/surgical benefits to **Patricia K. Brougher M.D., PA.**
I further understand a 60% fee will be added to my account in the event it is necessary for my account to be forwarded to a Collection Agency.

Signature _____**Date** _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES/NO

May we leave a message on your answering machine at home or on your cell phone? YES/NO

May we discuss your medical condition with any member of your family? YES/NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____