KARU MEDICAL ASSOCIATES

(A PATIENT CENTERED MEDICAL HOME)

PATIENT INFORMATION SHEET

PLEASE PRESENT ALL INSURANCE CARDS AND VALID IDENTIFICATION CARD (EXAMPLE: DRIVERS LICENSE)

Patient Name	Birthdate	SSN: *(for internal use only)* Marital Status *if listed as unknown, please change*	Sex
Patient Address		Join ***Follow My Health***—our patient portal—provide an email address:	
Preferred Phone	**Alternate Phone:**		*Work Phone:*

Preferred Contact Method: (circle one) *Phone Mail Portal* Driver's License #	Race: *(if blank, circle one)* American Indian/Alaska Native Hispanic Other Pacific Islander Asian More than 1 Race White Black/African American Native Hawaiian Refuse to Report	Ethnicity: *(circle one)* *Hispanic or Latino* *Not Hispanic or Latino* *Refuse to Report*

You may wish to authorize release of your health information to family members or others as you designate. We require the use of a PIN number. You have the option of selecting a PIN number or using the one assigned by us. You may provide this number to any individual who may have access to your private information. (*optional)* **PIN NUMBER REQUESTED (4 DIGITS)**

Usual Physician	Referring Physician	Preferred Language *(if other than English)*
Guarantor Name	Guarantor Address	PCMH –Ask us about our PCMH Brochure!
Emergency Contact Name	Emergency Contact Relationship	Emergency Contact Phone Numbers (*home, cell, work)*
Primary Insurance Name	Secondary Insurance Name	Tertiary Insurance Name
Primary Insured Date of Birth	Secondary Insured Date of Birth	**IS THIS RELATED TO WORK OR AUTO ACCIDENT? YES NO** **IF YES YOU MUST PROVIDE THE DATE OF ACCIDENT AND ALL BILLING INFORMATION**

Authorization to Pay Benefits to Physician:

1. I authorize Karu Medical Associates. to release to my insurance company any information regarding my treatment and diagnosis of my condition that they may consider appropriate to obtain payment for services rendered to me.
2. I also authorize and request such payment be made directly to these physicians for any amounts due for medical and surgical services.

If I am also a Medicare patient, I request payment of authorized Medicare benefits be made on my behalf to Karu Medical Associates for any services furnished to me. I authorize the holder of medical information about me be release to the Health Care Financing Administration and it's agents needed to determine these benefits payable for related services.

Patient Financial Obligations:

1. I understand that I am financially responsible to any charge not covered by my insurance or any non-covered benefits, including injections or laboratory tests necessary to diagnose or treat my condition.
2. Payment for services are due when rendered unless other arrangement have been made in advance.

Acknowledge of Receipt of Notice of Privacy Practices: The undersigned patient or legally authorized representative of patient acknowledges that he or she received a copy (or was offered) of the Karu Medical Associates Notice of Privacy Practices on the date indicated below.

I agree to Electronic Exchange of Information, including Community Share Exchange (medical record exchange), Immunization records, ePrescribe (electronic transmission of prescriptions and Formulary Exchange via Surescripts software and Pheresis.

_____ _____

Signed (patient or parent, if minor **Date**

RETURN THIS FORM TO ANY MEDICAL ASSISTANT ONCE IT IS COMPLETED PLEASE

Karu Medical Associates does not discriminate on the basis of race, ethnicity, religion, age, sex or marital status