

NARCOTIC PAIN

MEDICATIONS

DUE TO THE NATURE OF THE FOLLOWING

MEDICATIONS THE PROVIDERS OF

THE LESLIE CLINIC

WILL NOT BE ACCEPTING PATIENTS

WHO TAKE THESE MEDICATIONS:

ATIVAN ** XANAX ** VICODIN

HYDROCODONE ** OXYCODONE

LORTAB ** METHADONE ** NORCO

SOMA ** DIET PILLS ** SLEEPING PILLS

PATIENT INFORMATION- PLEASE PRINT

SOC SEC #: _____ MRN#: _____

Name: _____
 Last **First** **Mid Initial**

Address: _____

City: _____

State: _____ Zip Code: _____

SEX: Male Female

MARITAL STATUS: Married Single Divorced
 Partner Widowed Separated

PRIMARY CARE PHYSICIAN: _____

Home Phone: _____

Work Phone: _____ Ext: _____

Cell Phone: _____

Date of Birth: _____ - _____ - _____ Age: _____ yrs

Employer: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Email: _____ @ _____

REFERRAL

Who referred you to our clinic? **(PLEASE CHECK BOX)**

<input type="checkbox"/> Newspaper or Magazine	<input type="checkbox"/> Community or Company Health Fair	<input type="checkbox"/> Referred by a Physician: _____
<input type="checkbox"/> Recommended by friend or family member	<input type="checkbox"/> Treated by Physician in hospital	<input type="checkbox"/> Employer
<input type="checkbox"/> Drove by Location of Clinic	<input type="checkbox"/> Internet	<input type="checkbox"/> Insurance Plan Directory
	<input type="checkbox"/> Phone Directory (Yellow pages)	<input type="checkbox"/> Return Patient/ Not Applicable
		<input type="checkbox"/> Other: _____

SPOUSE/PARENT INFORMATION

Spouse/Parent Name: _____ Cell: _____

Employer: _____ Work: _____ Ext: _____

Work Address: _____ Spouse/Parent SEX: Male Female

City: _____ State: _____ Zip: _____ Spouse/Parent Date of Birth: ____/____/____

Occupation: _____ Social Sec. #: _____ - _____ - _____

EMERGENCY CONTACT INFORMATION

Emergency contact: _____ Cell Phone: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Relationship to Patient: _____

Patient Name: _____

PRIMARY INSURANCE

Patient's Relationship to Main Policy Holder: Myself Spouse Child OTHER: _____

Name of Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

ID# _____ Group # _____

Insurance Company's Phone Number: _____

Main Holder's Name: _____

Main Holder's Date of Birth: ____/____/____

Main Holder's Address: _____

Main Holder's Soc Sec#: ____-____-____

City: _____

State: _____ Zip: _____

SECONDARY INSURANCE

Patient's Relationship to Main Policy Holder: Myself Spouse Child OTHER: _____

Name of Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

ID# _____ Group # _____

Insurance Company's Phone Number: _____

Main Holder's Name: _____

Main Holder's Date of Birth: ____/____/____

Main Holder's Address: _____

Main Holder's Soc Sec#: ____-____-____

City: _____

State: _____ Zip: _____

GENERAL INFORMATION

Who is responsible for Payment?: Myself Other: _____ (FILL OUT BELOW)

Responsible Party Name: _____ Responsible Party DOB: ____/____/____ :

Relationship to Patient: Self Spouse Child OTHER SS# _____ - _____ - _____

Address: _____ Phone#: _____

RELEASE OF INFORMATION (spouse, children, parents, etc)

Who may we discuss your information with? For example: Medical issues/care, results, billing, etc.

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Preferred Language: English Spanish DECLINE OTHER: _____

Race: White African American Asian Native Hawaiian/Other Pacific Islander

Native American Indian/ Alaskan Hispanic Unknown DECLINE

Ethnicity (Origin): Not Hispanic or Latino Hispanic or Latino Unknown DECLINE

PREFERRED PHARMACY: _____ **LOCATION:** _____

I authorize release of any medical information necessary to process my claim to all my insurance companies. I authorize direct payment of medical benefits to the provider. I permit a copy of this authorization to be used in the place of the original. I consent for my photo to be taken. I understand that I am responsible for any amount not covered by insurance. I permit the faxing and electronic transmission of medical information to other health care providers, attorneys, or insurance companies involved in my care. I give my permission for messages to be left on my answering machine or sent by email. I, the undersigned authorize and consent to the rendering of medical care, including diagnostic procedures, and medical treatment by authorized members of The Leslie Clinic, PA, as may in their professional judgment be necessary for the above named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. I have received a copy of the Privacy Practices of the clinic. I permit this facility to obtain my medication history electronically.

Patient Name: _____

X _____
Signature (Patient or Parent/Guardian if minor)

Date: ____/____/____

The Leslie Clinic, PA - Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding your coverage.
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.
3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. **If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.**
5. **Claims 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.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits
7. **Nonpayment.** If your account is **over 60 days past due**, you will receive a letter stating that you have 10 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. You and your immediate family members will be discharged from this practice.
8. **Missed appointments.** Please help us to serve you better by keeping your regularly scheduled appointment. **Three or more No Show Appointments will cause immediate dismissal.**
9. **Discharge Policy.** This practice can discharge you for any reason. Your immediate family members may also be discharged. For 30 days our providers will only be available to you on an emergency basis only.

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

Signature of patient or responsible party

Date

