FRANKLIN FAMILY PRACTICE
4908 FRANKLIN AVENUE
DES MOINES, 50310
515-280-4930 fax 515-309-0686

Patient label: name & DOB

Date: _____/_____/_____ Preferred name_____ Preferred Pronoun_____

Patient Name: _____ _____ _____
Last First MI

Street Address: _____ Home Phone: _____

City: _____State_____ Zip _____ Mobile Phone: _____

Employer Name & Address: _____

Work Phone: _____ Sex: Male Female Transman Transwoman Other_____

Patient Date of Birth: _____ Legal Sex: Male Female

Social Security # _____ Spouse's/Partner's Name: _____

Emergency Contact (at another address) _____

Relationship to Patient _____ Phone Number: _____

PATIENT INSURANCE

1. PRIMARY Insurance Company Name:_____

Address/City/State/Zip_____

Policy Holder (Insured's Name)_____ Insured Date of Birth:_____

Policy Number_____Group Number_____

What relationship is Policy Holder to the Patient? Self or Other:_____

Patient sex listed on insurance_____

Is policy through Employer? If Yes, Employer's Name:_____

Effective Date of Policy:_____Work Phone:_____

2. SECONDARY Insurance Company Name:_____

Address/City/State/Zip_____

Policy Holder (Insured's Name)_____ Insured Date of Birth:_____

Policy Number_____Group Number_____

What relationship is Policy Holder to the Patient? Self or Other:_____

Patient sex listed on insurance_____

Is policy through Employer? If Yes, Employer's Name:_____

Effective Date of Policy:_____ Work Phone:_____

CONSENT TO TREAT/PAYMENT AUTHORIZATION:

1.) I authorize the healthcare providers of **Franklin Family Practice** to administer treatment as deemed necessary for care of the patient named above. I certify that, if I am not the patient, I am the parent or legal guardian of the patient. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment.

2.) I certify that I have read and understand the information provided to me on this date to the best of my ability. The questions asked verbally and in writing have been or will be accurately answered. I understand that providing incorrect information can be dangerous to my health.

3.) I authorize this office to release any information including diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office any benefits for our services that may otherwise be payable to me. I understand that my insurance carrier may pay less than the actual bill for services. All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. The patient/parent/responsible party is responsible for any unpaid balances. **Co-Payments will be made at the time of service.** I request that payment of authorized Medicare, Medicaid, or other insurance company benefits be made to **Franklin Family Practice** for any services furnished to me by the office. Regulations pertaining to Medicare and Medicaid assignment of benefits apply.

Franklin Family Practice has my permission to contact me the following ways:

____ Can leave message on my home answering machine ____ Can call my cell phone ____ Can call me at work

____ May make a reminder call for appointments ____ May send items by U.S. mail

_____ _____

Signature of Patient or Legal Representative Date

If patient is under the age of 18: Full Name of Parent or Legal Representative: _____

Address if different: _____

City _____State _____ Zip _____ Day Phone _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given an opportunity to read the **Franklin Family Practice NOTICE OF PRIVACY PRACTICES** and to have any questions answered before signing. **Franklin Family Practice** reserves the right to revise its **Notice of Privacy Practices** at any time. For a revised copy send a written request to **Privacy Officer, Franklin Family Practice, 4908 Franklin Ave, Des Moines, IA 50310**

I have the right to request that **Franklin Family Practice** restrict how it uses or discloses my personal health information. **Franklin Family Practice** isn't required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing, but this will only be effective beginning on the date it is received . If I do not sign this consent, or later revoke it, **Franklin Family Practice** may decline to provide treatment to me.

Signed: _____ Print Name _____Date _____

If signed by someone other than the patient, please indicate relationship to patient:

[ ] Parent or guardian of minor patient
[ ] Guardian or conservator of an incompetent patient
[ ] Beneficiary or personal representative of deceased patient

OFFICE USE ONLY: Employee Signature:_____Date_____

[ ] Efforts to Obtain: _____

Reason patient refused to sign: _____