

Annual Patient Information Update

Patient Name _____ DOB _____ ☐ Female ☐ Male
Address _____ Pharmacy _____
City, State, Zip _____ Emergency Contact:
Phone _____ Name _____
Phone _____ Phone _____
Email _____ Relationship _____

Primary Insurance: _____

Secondary Insurance: _____

Change in Medications: _____

Surgeries in past 12 Months: _____

Allergies: _____

Please initial below:

- _____ All copays/deductibles/balance due at time of visit
- _____ All return checks \$35 charge
- _____ No Show appointments \$35 (3 no shows, dismissal)
- _____ FMLA requires an appointment with the provider
- _____ Blue Cards \$5
- _____ PA's \$25 per Medication, 7-14 days to complete
- _____ Medications are not called in without an appointment
- _____ Allow 7-14 days for referrals to be complete, call if you have not heard an update.

Acknowledgment

The above information is true to the best of my knowledge: I hereby authorize my insurance benefits to be paid directly to the practice. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize Valley Internal medicine and pediatrics to release information necessary to secure the payment and benefits. I authorize the use of my signature on all insurance submissions.

I authorize that I have read the above office policies and know that I have access to Notice of privacy practice/ HIPAA and I agree to the authorization to treat.

Patient/Guardian Signature: _____ Date: _____