METRO MEDICAL ASSOCIATES

Patient Information

First Name: _____ **Last Name:** _____

Address: _____**Unit #:**_____

City: _____ **State and Zip:** _____

Cell Number: _____ **Home Number:** _____

Work Number: _____ **Email:** _____

How would you like us to contact you: ____ *Mail* ____ *Phone* ____ *Web Message*

In compliance with the Patient Affordable Care Act, we are required to obtain the following information about you:

1. Do you consider yourself Hispanic/Latino?

☐ Yes ☐ No ☐ Declined

2. Which category best describes your race? (Check any you feel apply)

☐ White
☐ American Indian/Alaska Native
☐ Asian (including from Indian subcontinent)
☐ Black or African American
☐ Native Hawaiian/Other Pacific Islander
☐ Declined

Preferred Language: _____

Sex: M / F **Date OF Birth:** _____ **Age:** _____

Social Security: _____-_____-_____

Marital Status: *Married* *Single* *Separated* *Divorced* *Widowed*

Occupation: _____

Whom do we thank for referring you? _____

In case of Emergency who should be notified: _____

Tel No.: _____ **Relationship:** _____

Self-Pay: _____ **Insurance Name:** _____

ID#: _____ **Group#:**_____

Assignment of Benefits:

I certify that I (or my dependent) have insurance coverage through ________________ and assign directly to Metro Medical Associates all insurance benefits for services rendered.

I understand that Metro Medical Associates is filing the claim as a service to me, but I am ultimately responsible for all charges whether or not paid by the insurance.

I hereby authorize Metro Medical Associates to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____ ____________

Signature of Patient, Guardian, or Personal Representative **Date**

____

Please print name of Guardian, Patient, or Personal Representative

____

Relationship to Patient

XxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxX

Acknowledgement of Receipt of Notice of Privacy Practices:

(Please review our Notice of Privacy Policy before signing this section.)

I _________________________, hereby acknowledge that I have received a copy of Metro Medical Associates' Notice of Privacy Practice.

I understand that Metro Medical Associates has reserved the right to amend their privacy practices that are described in the notice. I also understand that a copy of any amended Notice will be available at my request.

____________________________________ ________

Signature of Patient, Guardian, or Personal Representative **Date**

____

Please print name of Guardian, Patient, or Personal Representative

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Relationship to Patient