

Patient Information / Consent to Treat

PATIENT INFORMATION		Date	Date of Birth Month/Day/Year	
Last Name	First	MI	Gender	Male Female
Address			Marital status Single Married Divorced Separated	
City/State/Zip			Social Security #	
Home phone	OK to leave message? Yes No		Employer/School Name	
Work phone	Extension		Employment status	Full time Part time
Cell phone	E-mail		Preferred name	
Emergency contact		Relationship	Phone	
Responsible party		Relationship	DOB	
Responsible party address		Phone		
Pharmacy Name		Address	Phone #	

INSURANCE INFORMATION				
Primary insurance			Secondary insurance	
Subscriber name		DOB	Subscriber name DOB	
Policy number		Group number	Policy number Group number	
Address		City State	Address City State	
City/State/Zip			City/State/Zip	
Insured's Social Security #			Insured's Social Security #	

Financial Responsibility and Assignment of Insurance Benefits

I guarantee payment Matthew D. Acampora, MD and Internal Medicine Associates of Charlotte, P.A. of all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits, which would otherwise be payable to me, to Matthew D. Acampora, MD and Internal Medicine Associates of Charlotte, P.A. for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct.

Consent for Healthcare and Release of Medical Information

I voluntarily consent to health care treatment (Treatment) from Matthew D. Acampora, MD, Internal Medicine Associates of Charlotte, P.A. and their respective employees and agents. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatments or examinations by my caregivers. I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations. I have read this form. I have had the opportunity to ask questions and my questions have been answered.

Signature of Patient or Authorized Person: _____	Date/Time _____
Insured Party or Financial Guarantor (if different from above): _____	Date/Time _____

Acknowledgement of Receipt of Joint Notice of Privacy Practices

I have received a copy of Internal Medicine Associates of Charlotte, P.A. Joint Notice of Privacy Practices. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice on Internal Medicine Associates of Charlotte, P.A website at www.imacharlotte.com or by writing to the Privacy Officer, 8035 Providence Road, Suite 315, Charlotte, NC 28277.

Signature of Patient or Authorized Person: _____	Date/Time _____
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For Staff Use Only

Patient refused to sign after he/she received Joint Notice of Privacy Practices and was informed that signing the form merely acknowledges that the patient actually received the notice.

Signature of Staff: _____	Date/Time _____
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