Affordable Care Health Clinic

Patient Registration Information

Name**:** _____ Birthdate: _____ Sex:_____

Street: _____ City:_____ St: _____ Zip:_____

Home ph:_____ Cell ph:_____ Email: _____

Best way to contact you: _____ Best time to contact you: _____

Insurance: ***(for lab and referrals only):*** Company: _____Policy #_____

Emergency contact:: **_____ Relationship**:_____ **Phone:_____**

Street: _____ City:_____ St: _____ Zip:_____

Information Release: I hereby authorize Affordable Care Health Clinic to release medical information pertinent to my health to the following individuals and/or institutions: _____

How did you hear about us? _____

Voice Messages/Emails:
In case we cannot reach you in person, please ***put your initials*** by the number/email at which we may leave a message. If you prefer that we not leave a message at any number or email, please indicate by initialing the box "NO MESSAGES"

Home phone:_____ Cell phone:_____ Email: _____ NO MESSAGES: _____
Initials initials initials initials

Consent to Treatment:

Patient/Guardian is aware that the Nurse Practitioner will be providing care to the patient at Affordable Care Health Clinic, and consents and agrees to the treatment. The patient/guardian acknowledges that he/she has the right to refuse any treatment and to be informed of the consequences of refusing treatment. .

Payment Agreement:

Patient acknowledges that full payment is due at the time of treatment.

_____ _____
Signature of patient or guardian date

Privacy Practices:

My signature below acknowledges that I have received a copy of the Notice of Privacy Practices provided by Affordable Care Health Clinic, LLC. I understand that I have the right to receive additional copies of the Notice of Privacy Practices upon my request.

_____ _____
Signature of patient or guardian date

For minor patients only:

Parent/Guardian Name: _____

Street: _____ City:_____ St: _____ Zip:_____

Home ph:_____ Cell ph:_____ Email: _____