

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: _____