GHP
Grand Health
PARTNERS

Patient Demographic Form

Name: _____ Gender: Male Female
First Middle Last (Circle)

Primary Address: _____
City State Zip

Date of Birth: (mm/dd/yy) _____Social Security #: _____

Home #: _____ Cell#: _____ Work #: _____
Ok to leave a msg. (Circle one): Yes No Yes No Yes No

Email: _____

Ethnicity: (Circle one) Non-Hispanic Hispanic African American Caucasian
Race: _____Primary Language if not English: _____

Employer Name: _____ Marital Status:(circle one) S M D W Other: _____

How did you hear about us? (Circle one)
Radio Online Search GHP Patient Referral PCP/Doctor Therapist Community Event
Name of GHP patient or your PCP that referred you? _____

Insurance Information

Primary Insurance: _____ Policy Holder: _____

Policy Holder's Employer: _____ Policy Holder's DOB: _____

Patients Relationship to policy holder: _____ Specialist Copay:_____

Member ID: _____ Group ID: _____

Secondary Insurance: _____ Policy Holder: _____

Policy Holder's Employer: _____ Policy Holder's DOB: _____

Patients Relationship to policy holder: _____ Specialist Copay:_____

Member ID: _____ Group ID: _____

Primary Care Physician/Pharmacy

Primary Care Physician _____MD or DO (circle) Did this physician refer you: Yes or No

Address: _____
City State Zip

Physician Phone #: _____ Physician Fax #: _____

Preferred Pharmacy: _____ Phone #:_____ Fax #: _____

Pharmacy Address:_____
City State Zip

Emergency Contacts

Emergency Contact 1: _____

Name Relationship Phone #

May we discuss private medical information with Emergency Contact 1 (HIPAA)? (Circle) **Yes** **No**

Emergency Contact 2: _____

Name Relationship Phone #

May we discuss private medical information with Emergency Contact 2 (HIPAA)? (Circle) **Yes** **No**

Physicians will not be obligated to provide clinical services for any patient who is uncooperative or who does not qualify for the clinical services for valid medical reasons, and such patients may be discharged.

HIPAA COMPLIANCE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, as part of my healthcare, Grand Health Partners (GHP) originates, obtains, and maintains health information and medical records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future treatment or care. I was able to review Grand Health Partners *Notice of Privacy Practices* that provides a more complete description of how GHP uses and discloses my health information. I understand that I have the right to review the *Notice of Privacy Practices* prior to signing this and that I can ask for a copy of the *notice* to take with me. I understand that GHP reserves the right to change the *notice*, and prior to implementation, will post a copy of any revised *notice* in its waiting rooms and will provide me with a copy upon my request. I understand that I have the right to request restrictions as to how my health information is used, and or disclosed, to carry out treatment, payment, or healthcare options. I understand that GHP is not required to agree to the restrictions requested. GHP will consider my request, but I am aware that they are not legally required to accept it and will, given the complexity of multiple methods of dealing with information, most likely elect not to treat me or to disregard it in an emergency situation.

SIGNATURE BELOW INDICATES ACCURACY OF PATIENT INFORMATION, ACKNOWLEDGEMENT OF PRIVACY PRACTICES, AND ACCEPTANCE OF THE FOLLOWING:

- Authorization for providers of Grand Health Partners to examine me and render medical treatment deemed necessary for evaluations, management and treatment of my medical conditions; and to share any information with my primary care physician, any physician to which a referral is made or any other provider of health care products or services.
- I understand that Grand Health Partners may collaborate with other health care providers to coordinate, manage, and provide health care to me and consent to GHP sharing my health information and records electronically for the purpose of treatment, payment or operations, including improving the overall quality of health care services provided to me (example: avoiding unnecessary or duplicate testing, etc.)
- Authorization for Grand Health Partners providers to release to my insurance carrier or benefit plan and its agents any information needed to determine these benefits payable for related services.
- Authorization for direct payment of benefits to Grand Health Partners for services rendered by its providers. I understand I am financially responsible for any balance not covered by my insurance company/benefit plan.
- Authorization for Grand Health Partners to obtain pharmaceutical records from my pharmacy.

Name: _____

First Middle Last

Patient Signature: _____ Date: _____

Legal Representative (If Applicable): _____ Relationship: _____

Legal Representative Signature (If Applicable): _____ Date: _____