DOCTORS EICHENLAUB AND MAY

PATIENT INFORMATION UPDATE

Patient # _____

Name _____ Date of Birth _____ Age _____

Address _____ Social Security No. _____

_____ Marital Status: Married _____

_____ Single _____

Phone (home) _____ Other _____

(work) _____ Student: Full time _____

(cell) _____ Part time _____

Family Doctor _____ Referring Doctor _____

Primary Insurance Company _____ Secondary Insurance Company _____

Policy or ID# _____ Policy or ID# _____

Group# _____ Group# _____

Subscriber Name: _____ Subscriber Name: _____

Subscriber Social Security # _____ Subscriber Social Security # _____

Subscriber Date of Birth _____ Subscriber Date of Birth _____

Employer _____ Employer _____

I authorize my insurance benefits to be paid directly to Drs. Eichenlaub and May. I understand I am responsible for services considered non-covered by my insurance company. I understand that I may also be responsible for payment for services performed without the appropriate referral/authorization.

SIGNATURE: _____ DATE: _____

I authorize Drs. Eichenlaub and May to release my medical records and pertinent information to my insurer if requested for payment of a claim.

SIGNATURE: _____ DATE: _____

Please complete other side of form.

DOCTORS EICHENLAUB AND MAY

ACKNOWLEDGEMENT OF AWARENESS OF HIPAA NOTICE

Copy of Privacy Practices for DOCTORS EICHENLAUB AND MAY available.

_____
Name of patient

_____ _____
Signature of patient Date of receipt
(or patient's personal representative)

_____ _____
Signature of legal guardian Date of receipt

DESIGNATION OF PERSONAL REPRESENTATIVE

In addition to myself, I designate the following individual(s) as my personal representative and grant DOCTORS EICHENLAUB AND MAY permission to disclose (written and verbal) my Protected Health Information with the individual(s) named below.

_____ _____
Name of representative Relationship to patient

_____ _____
Name of representative Relationship to patient

I understand that I may revoke this authorization at any time.

[ ] I choose not to designate any other person as my personal representative

_____ _____
Signature of patient Date of receipt

The providers and staff of DOCTORS EICHENLAUB AND MAY are permitted to leave a voice message that may include Protected Health Information when calling the following:

_____ Home telephone _____

_____ Cell phone _____

_____ Other (identify) _____

I understand that it is my responsibility to notify the practice should the information noted above, or my preferences change.

_____ _____
Signature Date