

Wrightstown Family Medicine, P.C.

Paul Caracappa, D.O.

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2324 Second Street Pike, Wrightstown, PA 18940

215 598 1200

(Please fill in as completely as possible)

Last Name: _____ First Name: _____ Middle Initial: _____

Address 1: _____

Address 2: _____

ZIP: _____

City: _____ State: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Work Extension: _____

Employer: _____

Birth Date: _____

Social Security: _____

Gender: _____

Marital Status: _____

INSURANCE INFORMATION

IS YOUR VISIT RELATED TO AN INJURY:

- Workman's Compensation Date: _____
- Auto Accident Date: _____
- Other Date: _____
-

Adjuster: _____
Phone #: _____

Attorney: _____
Phone # _____

Do you have an HMO: YES NO

Primary Insurance: _____
Insurance ID #: _____ Deductible: _____
Name of Insured: _____ CoPay: _____
Relationship to Patient: Self _____ Spouse _____ Dependent _____
Responsible Party _____
Responsible Party's SS# _____ Date of Birth _____

AUTHORIZATION TO RELEASE INFORMATION: I / We hereby authorize Wrightstown Family Medicine to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.

CONSENT FOR TREATMENT: I / We hereby authorize Wrightstown Family Medicine to administer diagnostic and medical procedures as may be necessary for proper health care.

OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid for by my insurance company. I authorize insurance benefits to be paid directly to the Provider.

Signature: _____

This is to certify that the HIPAA Regulations have been explained to me verbally. In general, the HIPAA privacy rule gives the right to request a restriction on uses and disclosures of the protected health information(PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means. Please check all that apply.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER:

Home Phone/Answering Machine: Yes No
Spouse Notification: Yes No Name _____
Other (Please be specific) _____

HIPAA Signature: _____