GILMAN FAMILY PRACTICE (adult patient Age 19+)

TODAY'S DATE:		PATIENT EMAIL:		
☐ BRYCE H. GILMAN, DO ☐ KRISTINA A. STEWART, PAC ☐ LAURIE DIMLER, ARNP				
Patient Name: Last		First	M.I.	Gender: M F
Mailing Address:	Apt:	City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:		ext.
Which Phone Number Do You Authorize our Staff to Use to leave Voicemails Containing Private Health Information?				
Patient Date of Birth:		Age:	Patient SS#:	

PATIENT RACE: ☐ CAUCASIAN ☐ AFRICAN AM ☐ ASIAN ☐ NATIVE AM ☐ OTHER_____ ☐ MORE THAN ONE ☐ REFUSE

PATIENT ETHNICITY: ☐ LATINO HISPANIC ☐ OTHER ☐ REFUSED

PATIENT'S MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ WIDOW ☐ DIVORCED ☐ SEPARATED

Name of Patient's Spouse (if applicable):

*Emergency Contact:	Relationship to Patient:	Phone Number:

☐ EMPLOYED ☐ SELF EMPLOYED ☐ UNEMPLOYED ☐ RETIRED ☐ DISABLED (PATIENT EMPLOYMENT IF NOT A MINOR)
(USE GUARANTOR'S EMPLOYMENT INFORMATION FOR MINOR PATIENT OR SPECIAL NEEDS PATIENT)

Name of Employer:	Occupation:

PREFERRED PHARMACY NAME AND LOCATION

Pharmacy Name:	Pharmacy Location:

INSURANCE INFORMATION – WE MUST HAVE A COPY OF YOUR INSURANCE CARD AND PROOF OF IDENTIFICATION

Primary Insurance Co:	Secondary Insurance Co:
Group #:	Group #:
Policy ID# or Claim#	Policy ID# or Claim#
IS THE PATIENT THE SUBSCRIBER:YES ☐ NO ☐ IF NO THEN:	IS THE PATIENT THE SUBSCRIBER: YES ☐ NO ☐ IF NO THEN:
Subscriber's Name:	*Subscriber's Name:*
Subscriber's Employer:	*Subscriber's Employer:*
Subscriber's Date of Birth: / /	*Subscriber's Date of Birth:* / /
Subscriber's Relationship to Patient:	*Subscriber's Relationship to Patient:*

Release of Benefits Information

I authorize my insurance benefits to be paid directly to Drs. Gilman, Curalli and Gilman for services provided by them. I understand that the doctors' office will bill my insurance as a courtesy and that I am responsible at the time of service for all co-payments, deductibles and non-covered services. I authorize the release of information required to process my claims. (If not signed, payment is due at time of service.)

Patient/Authorized Signature:	Date: \ \
Insurance Subscriber's Signature:	Date: \ \

Check out our Patient Portal. We will send you an invitation to join the patient portal. We will send you PRIVATE health information. Only use your personal email address.

Email:_____ If you sign up for a Portal account,

Do you prefer medical reminders sent by ☐ US mail or ☐ Patient Portal?

Complete the reverse side.....

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Our notice of Privacy Practices provides information about how we may use and disclose Protected Health Information (PHI) about you.

Today's Date:_____

Patient Name:_____Date Of Birth:_____Age:_____

☐ I give Dr. Bryce H. Gilman and his staff permission to use and disclose all (without exclusion) protected health information about me for treatment, payment and health care operations.

PERMISSION TO RELEASE PROTECTED HEALTH INFORMATION TO A FAMILY MEMBER, CAREGIVER OR OTHER PERSON.

☐ I authorize Dr. Bryce H. Gilman and his staff to release my Protected Health Information to:

Name:	Relationship:
Name:	Relationship:

Please exclude/include the following protected health information: (please check at least one box.)

☐ Include All Protected Health Information

☐ Exclude HIV (Aids) ☐ Exclude Sexually Transmitted Diseases

☐ Exclude Mental Disorders ☐ Exclude Drug and/or Alcohol Use

Additional Exclusions (if any)_____

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or health-care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you will receive our revised copy. By signing this form, you consent to our use and disclosure of Protected Health Information about you for treatment, payment and health-care operations. You have the right to revoke this consent in writing except where we have already made disclosures in reliance on our prior consent.

Patient Signature_____Date_____

This document will automatically expire after 1 year.

*If we cannot reach you for medical or billing reasons, we may verify your personal contact information by calling your emergency contact. Also, the emergency contact may be called if you have a medical emergency in our office.