



## ADULT NEW PATIENT FORM

Please fill out completely.

MOORE-SMITH  
COMPREHENSIVE CARE

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Preferred Contact  Home Phone  Work Phone  Cell Phone  Email  Postal Mail

Marital Status \_\_\_\_\_ Spouse Name \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Language \_\_\_\_\_ Ethnicity  Hispanic or Latino  Not Hispanic or Latino

Race  Black or African American  White  Asian  Other \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_ Email Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy City: \_\_\_\_\_

### Responsible Party (if other than patient)

Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Primary Insurance

Company \_\_\_\_\_ ID/Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Phone (\_\_\_\_\_) \_\_\_\_\_ Is this policy through your employer? Y / N Spouse's employer? Y / N

Employer \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

### Secondary Insurance

Company \_\_\_\_\_ ID/Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Phone (\_\_\_\_\_) \_\_\_\_\_ Is this policy through your employer? Y / N Spouse's employer? Y / N

Employer \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_





**MOORE-SMITH**  
COMPREHENSIVE CARE

## **ASSIGNMENT OF BENEFITS**

**Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered.**

### **Insurance Authorization and Assignment of Benefits**

I hereby authorize Moore-Smith Comprehensive Care, LLC, and any of its employees or agents, to release any medical or other information necessary to process my insurance claims.

I authorize and assign directly to Moore-Smith Comprehensive Care, LLC all medical and/or surgical benefits, including major medical benefits, otherwise payable to me under my insurance policy or other health benefit plan for services rendered.

I understand that:

- This assignment will remain in effect until revoked by me in writing.
- I am financially responsible for all charges whether or not paid by my insurance.
- If my insurance company sends payment directly to me for services provided by this practice, I will immediately forward that payment to Moore-Smith Comprehensive Care, LLC.
- I am responsible for obtaining necessary referrals or authorizations as required by my insurance plan.

### **Financial Responsibility**

I understand that co-payments, deductibles, and non-covered services are due at the time of service unless prior arrangements have been made. In the event of non-payment by my insurance carrier, I agree to be responsible for all reasonable collection costs, attorney's fees, and court costs incurred by Moore-Smith Comprehensive Care, LLC, in the collection of my account.

**I have read and I understand the information above. I agree to be financially responsible for all charges as discussed above.**

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_



**MOORE-SMITH**  
COMPREHENSIVE CARE

**PATIENT CONTACT RECORD**

Patient Name: \_\_\_\_\_

The HIPAA Privacy Rule gives individuals the right to restrict release of their Private Health Information (PHI). A copy of Moore-Smith Comprehensive Care, LLC’s Notice of Privacy Practices, is included in this packet.

**RECEIPT OF NOTICE OF PRIVACY PRACTICES**  
**WRITTEN ACKNOWLEDGEMENT OF FORM**

I, \_\_\_\_\_, have received a copy of Moore-Smith Comprehensive Care, LLC’s Notice of Privacy Practices.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL HISTORY TO ANOTHER INDIVIDUAL**

Please list the individual(s) you will allow Moore-Smith Comprehensive Care, LLC to release or discuss your PHI with. Do not list other physicians.

Name	Relationship	Phone Number

**AUTHORIZATION TO OBTAIN MEDICATION HISTORY**

I, \_\_\_\_\_, hereby authorize Moore-Smith Comprehensive Care, LLC to obtain/download my medication history from Pharmacies and/or Pharmacy Benefit Managers. This authorization will allow my physician to check drug-to-drug interactions for any new prescriptions he/she may prescribe and to facilitate electronic pharmacy prescriptions. I understand this authorization will remain in effect until revoked by me in writing.

**AUTHORIZATION TO LEAVE RECORDED MESSAGES**

I give Moore-Smith Comprehensive Care permission to leave protected health information on an answering machine or voicemail. (Circle Yes or No)                      YES                      NO

**AUTHORIZATION OF ELECTRONIC CORRESPONDENCE**

I give Moore-Smith Comprehensive Care permission to communicate protected health information with me via email, text message and other electronic mechanisms. I understand the potential risks associated with electronic correspondence.

(Circle Yes or No)                      YES                      NO

Signature \_\_\_\_\_

Date \_\_\_\_\_