Patient Demographics

Date_____Last Name_____First_____Middle _____
Pt Acct #_____Address_____City_____State_____Zip_____
Sex : Male◯Female◯Age_____Date of Birth_____Social Security_____
Married◯ Widowed◯ Single◯ Minor◯ Separated◯ Divorced◯ Partnered◯ for ____years
Your Occupation_____Employer_____Employer Phone_____
Employer Address_____ City_____State_____Zip_____
Spouse Name_____Spouse date of birth_____Spouse Employer_____
Whom may we thank for referring you?_____

Home Phone_____Cell Phone_____Best time to call_____
Patient Email:_____ Can we text you? YES NO
Emergency Contact Name: _____ Relationship: _____ Number: _____

Insurance/Billing

Who is resposible for this account?_____Relationship to patient_____
Responsible Party Birthdate_____Social Security Number_____
Insurance Company_____Group Number_____

Is patient covered by additional insurance? Yes_____No_____ Subscriber Name_____
Relationship to patient_____ Birthdate_____Social Security #_____
Additional Insurance Company_____Group #_____

Insurance Assignment and Release

I certify that I have insurance coverage with (name of insurance company) _____ and assign directly to Linda Boarman FNP all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am finacially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
Linda Boarman FNP may use my health information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Medicare Authorization
I request that payment of authorized Medicare benifits and, if applicable, Medigap benefits, be made either to me or on my behalf to Linda Boarman FNP for any services furnished to me by my provider.
To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine benefits or benefits for related services.

Signature of Patient/Parent/Guardian/Personal Representative_____

Printed Name of Patient/Parent/Guardian/Personal Representative_____

Date_____Relationship to Patient_____

Linda Boarman, FNP

6071 State Route 54
Philpot, KY 42366

Patient Confidentiality Consent

The office of Linda Boarman, FNP has my permission to disclose my protected health information to the following significant others:

Name	Relationship	Phone
1.		
2.		
3.		
4.		
5.		
6.		

May we leave voicemail regarding test results or appointments? If yes, provide number:

_____(cell)_____(home)_____(work)

Preferred Pharmacy: _____

Agreement to Pay/Authorization for Insurance Payments

I agree to pay for all fees or any portions not covered by medical insurance at the time of service. I am responsible for full payment of fees not paid by insurance within 30 days of receiving bill from Linda Boarman FNP I agree to be responsible for any fees required to collect payment for services including attorney and court costs, collection agency fees, pre-judgment and/or post judgment interest at the current legal rate. I hereby authorize my insurance company to make payment directly to unless I pay in full at the time of service.

Collection Fee

If unpaid balance is assigned to a third-party collection agency or collection is placed with an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee of 33% will be added to my account. I agree to pay reasonable attorney fees and court costs. I understand and agree to the above terms.

Medical Authorization

I request that payment of authorized Medicare Benefits for any services furnished to me by Linda Boarman FNP be made to either me or on my behalf to Linda Boarman FNP. I authorize the holder of medical or other information to release to the Health Care Financing Administration (Medicare) and its agents, any information needed to determine this or any related Medicare/Medicaid claim to the Social Security Administration or its intermediaries or carriers.

Medical Record Release

If it is necessary for any of my medical records, including progress notes and laboratory results to be sent to another health care provider for medical reasons and to facilitate timely healthcare, I authorize Linda Boarman FNP to do so. I authorize the release of medical information, necessary to process my claim, to my insurance company, Workman's Comp plan, Social Security, Medicare/Medicaid, or any representative acting on my behalf. I further authorize the release of my medical records to any individual or organization, engaged by Linda Boarman FNP my medical provider, or my third-party payer (insurance company), to contact quality improvement and/or utilization review. I authorize the release of necessary medical information to other medical providers for the purpose of referral or in the daily activity of healthcare as necessary. I permit a copy of this authorization to be used in place of the original. I hereby release Linda Boarman FNP for all legal liability that may arise from the disclosure of such information.

Signature of Patient/Guardian/Representative_____Date_____

Printed Name: _____ Relationship to Patient: _____

Linda Boarman FNP

6071 HWY 54
PO BOX 70
PHILPOT, KY 42366
270-713-0177 (phone)
270-713-0185 (fax)

Request for Release of Medical Records FROM:

Physician/Facility_____

Address_____

City_____State_____Zip_____

☐ All records ☐ Pertaining to: _____

Physician/Facility_____

Address_____

City_____State_____Zip_____

☐ All records ☐ Pertaining to: _____

Physician/Facility_____

Address_____

City_____State_____Zip_____

☐ All records ☐ Pertaining to: _____

I hereby request a copy of my medical records be released TO:

Linda Boarman, FNP

X_____ **X**_____

Patient/Guardian/Representative Signature Date

_____**(Printed Name)**

Date of birth: _____ **Last 4 of SSN:** _____