

<b>Last Name</b>			<b>First</b>	<b>M.I.</b>	<b>Today's Date:</b>
<b>Social Security Number:</b>					<b>Date of Birth:</b>
<b>Marital Status: <i>Please circle one</i></b> Child   Single   Married   Widowed   Divorced   Separated Other					<b>Race: <i>Please circle one</i></b> Caucasian (White)   African American Native American   Hispanic   Other
<b>Home Address:</b>					<b>Home Phone:</b>
<b>City, State, Zip:</b>					<b>Cell Phone:</b>
<b>E-mail address:</b>					<b>Primary Physician:</b>
<b><u>PATIENT EMPLOYMENT</u></b>					<b>EMERGENCY CONTACT NAME &amp; PHONE:</b>
<b>Employer Name &amp; Address:</b>					<b>Relationship:</b>
<b>Work Phone:</b>					
<b>Occupation:</b>					

**OPTIONAL AUTHORIZATION TO RELEASE INFORMATION**

I, \_\_\_\_\_, give Cedar Hill Medical, P.C., permission to speak with the following people regarding my medical information. This authorization is valid until I provide Cedar Hill Medical, P.C. written revocation of it.

Name	Phone Number	Relationship to Patient
Name	Phone Number	Relationship to Patient

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

The Notice of Privacy Practices for Cedar Hill Medical, P.C. is available for you to review. I understand that I may request a copy of the notice at any time.

**ACUPUNCTURE SERVICES / MENTAL HEALTH SERVICE WAIVER**

I understand that my insurance will be billed for acupuncture/mental services and that I will be liable for the entire bill if my insurance does not cover these services.

- *I hereby state that all information listed above, to my knowledge, is accurate.*
- *I authorize Cedar Hill Medical, P.C. to contact all parties listed above in case of emergency, medical claims and to carry out all necessary healthcare operations.*
- *I also understand that if my insurance company(s) denies payment, because services are not covered under my insurance plan, that I will be responsible for payment or contacting them with any questions on billing. This may include office visits, laboratory or other rendered services.*
- *I understand that CHM may disclose my PHI to obtain payment from third parties that may be responsible for such costs.*

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian Signature if applicable:** \_\_\_\_\_ **Date:** \_\_\_\_\_