UnityPoint Clinic

Multi-Specialty
115 8th St., NE
Cedar Rapids, IA 52401

OFFICE USE ONLY		
Date	Account #	Doctor

PATIENT INFORMATION

First Name (Legal)	Middle Initial	Last Name	Previous Name	Age	DOB	Sex	Marital Status

Street Address			Patient Employer
City	State	Zip	Patient's Occupation
Phone Number	Social Security Number		Patient Cell Phone #
In Case of Emergency (Friend or Relative who does not live with you) Phone #			Mom's Cell Phone # / Dad's Cell Phone # Patient's Email
Spouse's Name/Parents Name (if under 18)	Spouse/Parent Employer Name		

Please specify the race you most closely identify with	Language Spoken	Do you consider yourself to be ethnically Hispanic or Latino? ☐ Yes ☐ No

BILLING INFORMATION

Responsible Party/Custodial Parent (if same as above, skip to insurance information)			Phone Number	Relationship to Patient ☐ (1) Self ☐ (2) Spouse ☐ (3) Child ☐ (4) Other
Street Address			Responsible Party Cell Phone Number	
City	State	Zip		

PRIMARY INSURANCE

Insurance Company Name & Address	
Effective Date	
Policy Holder's Name	Relationship to Patient
Policy Number	Group Number
Policy Holder's SS Number	Policy Holder's Date of Birth
Policy Holder's Employer Name	
Phone Number	

WORKERS COMPENSATION

Company/Work Comp Carrier	
Contact Person & Phone Number	
Policy Number	
Workers Compensation Employer Name	

SECONDARY INSURANCE (Medicare supplement or secondary insurance)

Insurance Company Name & Address	
Policy Holder's Name	Relationship to Patient
Policy Number	Group Number
Policy Holder's Social Security Number	Policy Holder's Date of Birth
Policy Holder's Employer Name	

THIRD INSURANCE (tertiary)

Insurance Company Name & Address	
Policy Holder's Name	Relationship to Patient
Policy Number	Group Number
Policy Holder's Social Security Number	Policy Holder's Date of Birth
Policy Holder's Employer Name	

If Medicare: Are you employed? ☐ Yes ☐ No Are you covered by an employer health insurance? ☐ Yes ☐ No

PATIENT REFERRED BY:
- ☐ (1) Physician Referral
- ☐ (2) Family & Friends
- ☐ (3) Phone Book
- ☐ (4) Website (which site/s)

  _____

  _____
- ☐ (5) Advertisement

NAME OF REFERRING DOCTOR: _____
ADDRESS: _____

_____

NAME OF FAMILY DOCTOR: _____
ADDRESS: _____

_____

Please complete reverse side.

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PATIENT _____

MR. # _____ DOB _____

PLEASE LIST OTHER IMMEDIATE FAMILY MEMBERS:

LAST NAME	FIRST	M.I.	BIRTHDATE

FOR FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I understand that I am financially responsible to pay IPC its usual charges for all services received through IPC, including any balances not covered by my insurance carrier(s). I hereby assign all of my rights to receive any and all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier(s) to IPC and direct that payment of proceeds be made directly to IPC.

RECORDS RELEASE FOR CLAIMS PAYMENT

I authorize the release of medical record information or excerpts thereof to any insurance company or third party payor **for utilization management audit purposes and/or the purposes of verifying the services rendered and obtaining payment** of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization.

My signature below represents I have read and understand the terms and statements above.

This authorization form will remain in effect for 1 year from signature date unless revoked by me in writing, and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this authorization form is to be considered as valid as an original.

_____ _____
Patients signature Date

_____ _____
Parent/Guardian's Signature Date

I have witnessed the completion of this authorization form.

_____ _____
Employee signature Date

Notice of Privacy Practices

I acknowledge that I received a Notice of Privacy Practices today _____ (patient initials)