

DATE: \_\_\_\_\_  
(Fecha)

**PATIENT INFORMATION**  
**INFORMACION DEL PACIENTE**

Full Legal Name (Patient) \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Nombre Completo) Last(Apellido) First(Nombre) M (Sexo) (Fecha de Nacimiento)

Social Security Number: \_\_\_\_\_ Referring MD(who referred you?) \_\_\_\_\_  
(# de seguro social) (refiriéndose médico)

Mailing Address(Street & PO Box): \_\_\_\_\_  
Direccion (Calle y PO Box)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
(Ciudad) (Estado) (Codigo) (Telefono de casa)

Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Employer's name: \_\_\_\_\_  
(Ocupacion) (Telefono de trabajo) (Nombre del empleador)

Cell Phone: \_\_\_\_\_ Would you like this listed as your primary contact number? Yes No  
(Celular) (Este es su numero primario) Si No

Email Address: \_\_\_\_\_  
(Correo Electronico)

Emergency Contact: \_\_\_\_\_  
(Contacto en caso de emergencia)

Relationship: \_\_\_\_\_ Address: \_\_\_\_\_ Phone#: \_\_\_\_\_  
(Relacion) (Direccion) (Telefono)

If patient is a minor: Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_  
(Si el paciente es menor): (Nombre del padre) (Nombre de la madre)

Father's work phone: \_\_\_\_\_ Mother's work phone: \_\_\_\_\_  
(Telefono de trabajo del padre) (Telefono de trabajo de la madre)

**INSURANCE INFORMATION: Please fill out the information below if the patient is not the primary on the insurance plan.**

**INFORMACION DE SEGURO: Porfavor llene la informacion de la persona principal asegurada**

We participate with many insurance companies. If your insurance company is one with whom we participate, we must have complete and current information in order to process your claim.

Participamos con muchas companias de seguro. Si su compania es una de las que participamos tenemos que tener infromacion completa y actual para procesar su factura.

Name of person to whom the policy is issued: \_\_\_\_\_  
(Nombre del Asegurado)

Policy holder's date of birth: \_\_\_\_\_ Policy holder's social security number: \_\_\_\_\_  
(Fecha de Nacimeineto) (#de seguro social)

**CONSENT FOR TREATMENT**

I hereby give consent to the physician and staff of High Country Health Care, P.C. to render such care and treatment as might be required by my condition. Such care can include, but is not limited to diagnostic procedures such as laboratory and imaging examinations, rehabilitation, medical and/or surgical treatment and injections.

Patient/Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**PAYMENT POLICY**

High Country Health Care will file all insurance for Summit County residents as a courtesy. If High Country Health Care is not contracted with your insurance company, you will be responsible for payment towards your deductible and any co-insurance for the visit at the time of service. If you are not a resident of Summit County, and do not have an insurance that we are contracted with, payment will be due at the time of service. We will provide you with the information necessary for you to file your claim with your insurance company. Any unpaid patient balance will accrue at 1-1/2% monthly billing charge after 90 days. Any collection fees, attorney fees, or returned check fees are the responsibility of the adult persons named on the account.

In addition, I assign directly to High Country Health Care, P.C. all surgical and/or medical benefits, if any, otherwise payable to me for services rendered.

I understand that if I have not listed any insurance above, or if the insurance I have listed is not contracted with High Country Health Care, that I am responsible for any out of network deductibles and co-insurance at the time the service is rendered.

I also verify that all the information contained on these information sheets is true and correct, to the best of my knowledge and belief. I authorize High Country Health Care to release my complete records to my insurance company in order to process my claim and to or from other physicians or medical facilities that may be pertinent and necessary to care and treatment.

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

**Permiso Para Tratamiento**

Por la presente doy el consentimiento al medico y personal de HCHC a rendir tal cuidado y tratamiento cual se necesario para mi condicion. Tal cuidado puede incluir pero no es limitado a procedimientos diagnosticos tal como exámenes de laboratorio, imagenes, rehabilitacion, tratamiento medico y/o quirosurgico y inyecciones.

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

Pasaremos la cuenta a la compania de seguro para los residentes del condado de Summit como una cortesia. Si usted no es residente del condado de Summit, el pago sera debido en el tiempo del servicio. Si HCHC no esta contratado con su compania de seguro, usted sera responsable por el pago en total en el tiempo del servicio. Le daremos toda la informacion necesaria para que usted submita su reclamo con la compania de seguro y reciba su dinero. Cualquier balance no pago despues de 90 dias acumulara 1- 1/2% de cargo ensual. Cualquier cargo de coleccion, cargo de abogados, or cargo de cheques devultos son la responsablebiladada de la persona adulta nombrada en la cuenta.

Adicionalmente, yo directamente asigno a HCHC todos los beneficios medicos y/o quirosurgicos que serian pagos a mi por servicios rendidos.

Entiendo que si yo no nombrado ningun seguro arriba, o la compania de seguro que he nombrado esta contratada con HCHC, yo soy responsable por el pago en completo para los servicios rendidos.

Tambien verifico que toda la informacion contenida en este documento es correcta y verdadera a lo mejor de mi conocimiento. Autorizo a HCHC que libere mis registros medicos completos a mi compania de seguro para procesar mi reclamo y a sotoros medicos o facilidades meicas que puedan ser pertinentes y necesario al cuidado y tratamiento.

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