NOVUS clinic

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____ Sex: **M F**

Address _____ City / State / Zip+4: _____

Primary Phone _____ **Is this a Cell? Y / N** | Secondary Phone _____ **Is this a Cell? Y / N**

Date of Birth _____ Social Security No. _____ Marital Status _____

Ethnicity (circle one): Hispanic or Latino | Non Hispanic or Latino | Declined to answer

Race (circle all that apply): American Indian/Alaska Native | Asian | Black/African American | Declined to answer |

Native Hawiian/Other Pacific Islander | Other Race | White

Preferred Language: _____Email _____

Family Doctor _____ Doctor Phone _____

Physician who referred you: _____

PATIENT EMPLOYER/PLACE OF EMPLOYMENT:

Employer _____ Occupation _____

Employer Address _____ City / State / Zip+4: _____

RESPONSIBLE PARTY (if patient is under 18 years of age):

Last Name _____ First Name _____ Middle Initial _____ Relation _____

Address _____ City / State / Zip+4: _____

Primary Phone _____ Cell Phone _____ Work Phone _____

EMERGENCY CONTACT INFORMATION:

Last Name _____ First Name _____ Middle Initial _____ Relation _____

Home Phone _____ Cell Phone _____ Work Phone _____

REFERRAL INFORMATION: How did you hear about our office?

___Radio ___TV ___Billboard ___Newspaper ___Website

Friend/person that referred you: _____

INSURANCE COVERAGE #1: Co-Pay: _____ ____**Medical Plan** ____**Vision Plan**

Insurance Name _____ Policy/ID # _____ Group # _____

Insured Name _____ Date of Birth _____ Relation _____ Social Security No. _____

Insured Employer/Group Name _____ Phone number _____

INSURANCE COVERAGE #2: Co-Pay: _____ ____**Medical Plan** ____**Vision Plan**

Insurance Name _____ Policy/ID # _____ Group # _____

Insured Name _____ Date of Birth _____ Relation _____ Social Security No. _____

Insured Employer/Group Name _____ Phone number _____

INSURANCE COVERAGE #3: Co-Pay: _____ ____**Medical Plan** ____**Vision Plan**

Insurance Name _____ Policy/ID # _____ Group # _____

Insured Name _____ Date of Birth _____ Relation _____ Social Security No. _____

Insured Employer/Group Name _____ Phone number _____

The Above information is true to the best of my knowledge. I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to be paid to System Optics, Inc. I acknowledge that I am financially responsible any balance (deductibles, coinsurance, copays, and non-covered services) my insurance determines is my responsibility.

Signature: _____ Date: _____

I authorize Novus Clinic, (System Optics, Inc.) to view my external prescription history via SureScripts or any eprescribe service. I understand that prescription history from multiple, other unaffiliated providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff here. It may include prescriptions back in time for several years. My signature certifies that I read and understand the scope of my consent and that I authorize the access.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Dear Patient:

We care about the privacy of your health care information. Our policies for protecting your healthcare information are explained in our Notice of Privacy Practices.
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. Please write in the names of personal contacts we may share your medical information with.

_____	_____
Name	relationship
_____	_____
Name	relationship
_____	_____
Name	relationship

I acknowledge that I have received a copy of The Novus Clinic Notice of Privacy Practices.

_____

Please Print Your Name Here

_____

Signature Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- o The patient refused to sign
- o Due to an emergency situation it was not possible to obtain acknowledgement
- o We were unable to communicate with the patient.
- o Other (please provide specific details)

_____

_____

Employee Signature