

Patient Insurance Information
(Please also bring a copy of your insc card with you)

Name of Insurance Company: _____

Address: _____

City/ St/ Zip: _____

Insc Company Phone Number: _____

Patient Relationship to Subscriber: _____ Subscriber's Soc Sec #: _____

Subscriber's Full Name: _____ Subscriber's DOB: _____

Subscriber's Address: _____

City/ St/ Zip: _____

Subscriber's Phone Number: _____

Subscriber's Employer Name: _____

ID/Policy #: _____ Group #: _____ Co-Pay Amount: \$ _____

Guarantor (Person Responsible for Payment): _____

If different than **patient** or **subscriber**, please provide information below. If **same**, please circle which.

Patient Relationship to Guarantor: _____ Guarantor's Soc Sec #: _____

Guarantor's Full Name: _____ Guarantor's DOB: _____

Guarantor's Address: _____

City/ St/ Zip: _____

Guarantor's Phone Number: _____

Guarantor's Employer Name: _____

Signature Page

****Please print this page, review the contents thoroughly, sign, and bring with you to your first appointment.****

I. Consent for Treatment

I authorize Nanopractice PDX and Dr. Chrissie Ott to provide ongoing medical care, treatment, and procedures as needed. I understand that no guarantees can or will be made as to results of care, treatment, or medication prescribed.

If the patient is a minor, then proxies for medical consent (others who may bring the child in for medical visits) include the following in addition to the parents or legal guardians of the child: _____

II. Financial Agreement

I understand and agree that I am financially responsible for all services provided. As a courtesy, Dr. Ott will bill my insurance carrier. Regardless of outstanding insurance claims, full payment is due within 60 days of the date of service. Co-pays are due at the time of service. If collection procedures are required, I am responsible for their cost. Some services may not be covered by insurance policies and they remain the patient's financial responsibility.

III. Assignment of Benefits

I authorize my insurance benefits be paid directly to Nanopractice PDX. I certify that all information given in applying for payment under my health insurance plan is correct, and authorize verification of coverage by Dr. Ott or staff. Photocopy of this authorization shall be considered as effective and valid as the original.

IV. Consent to Release of Information

I authorize Nanopractice PDX to release upon request to my insurance carriers or other reimbursing agencies information about my identity, treatment, diagnosis, prognosis, and/or other services rendered including information about substance abuse, HIV/AIDS, or other sexually transmitted or reportable diseases as permitted by law, thus releasing Nanopractice PDX and Dr. Chrissie Ott and staff of any liability for furnishing such information. I understand that information may be released through electronic or paper media.

V. Notice of Health Information Practices

I acknowledge that I have been provided with access to or a copy of the Notice of Privacy Practices (Posted on Website).

VI. Approved Methods of Communication: (please circle your choices)

I **do/ do not** consent to the leaving of **voice mail** regarding medical results and appointment reminders.

I **do/ do not** consent to the leaving of **e- mail** regarding medical results and the receipt of electronic forms and appointment reminders.

VII. Acknowledgement of Practice Policies:

I hereby acknowledge that I have reviewed or will immediately review the practice policies as posted at www.nanopracticepdx.com and agree to abide by these practice policies while under the care of Dr. Chrissie Ott. This includes but is not limited to policies on missed appointments, refills, narcotics, terms for termination of care, after hours care, and more.

VIII. Signature of Patient or Guardian: _____ **Date:** _____

Printed Name: _____

