LUMINA
NANCY A. CARLSON, M.D.

## PATIENT INFORMATION

LAST NAME_____ FIRST NAME _____

MAILING ADDRESS _____ CITY, STATE, ZIP CODE _____

BILLING ADDRESS, if different _____ CITY, STATE, ZIP CODE _____

HOME PHONE _____ CELL PHONE _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

EMAIL ADDRESS _____

## EMPLOYER INFORMATION

COMPANY NAME _____

ADDRESS _____ CITY, STATE, ZIP CODE _____

WORK PHONE _____ EXT. _____

## RESPONSIBLE PARTY FOR BILLING

SELF ___ OTHER ___ (*LIST BELOW)*

LAST NAME _____ FIRST NAME _____

MAILING ADDRESS _____ CITY, STATE, ZIP CODE _____

HOME PHONE _____ CELL PHONE _____

EMERGENCY CONTACT _____ PHONE NUMBER _____

**ONE TIME AUTHORIZATION FOR MEDICARE AND THIRD PARTY INSURANCE CARRIERS**

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO DETERMINE MY BENEFITS PROCESS ANY CLAIM FOR SERVICES PROVIDED.

SIGNATURE _____
DATE _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO DETERMINE MY BENEFITS AND TO AND TO PROCESS ANY CLAIM FOR SERVICES PROVIDED.

SIGNATURE _____
DATE _____

## INSURANCE INFORMATION

INSURANCE CARRIER _____ SUBSCRIBER NAME _____ DOB _____
MEMBER ID # _____ GROUP # _____
RELATIONSHIP TO PATIENT SELF ___ SPOUSE ___ PARENT ___ OTHER ___
SECONDARY INS.CARRIER _____ SUBSCRIBER NAME _____ DOB _____
MEMBER ID # _____ GROUP # _____
RELATIONSHIP TO PATIENT SELF ___ SPOUSE ___ PARENT ___ OTHER ___

## PHARMACY INFORMATION

PHARMACY NAME _____
ADDRESS _____ CITY, STATE, ZIP CODE _____
PHONE _____ ARE YOU AN ESTABLISHED CUSTOMER? _____

PRIMARY CARE PHYSICIAN _____ PHONE _____

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PATIENT NAME _____ DATE _____

## PROTECTED HEALTH INFORMATION DISCLOSURE

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PREFERRED NUMBER _____

CAN WE LEAVE THE FOLLOWING MESSAGE IN THE EVENT WE RECEIVE YOUR VOICEMAIL?

| | | |
|---|---|---|
| APPOINTMENT INFORMATION | YES | NO |
| MEDICAL INFORMATION | YES | NO |
| BILLING INFORMATION | YES | NO |

PLEASE LIST WITH WHOM WE CAN SPEAK TO ABOUT THE FOLLOWING (OPTIONAL)

APPOINTMENT INFORMATION _____

MEDICAL INFORMATION _____

BILLING INFORMATION _____

## OUR CANCELLATION POLICY

We respectfully request that 24 hours notification be given if you are going to miss your scheduled appointment. This ensures the office staff time to fill the vacant spot.

All appointments that are canceled without 24 hours' notice will be billed $50.00

## NOTICE OF PRIVATE PRACTICES

A copy of Nancy Carlson Fisher, MD, PC's Notice of Privacy Practices are available upon request.

I, _____, acknowledge receipt of Nancy Carlson Fisher, MD, PC's Notice of Privacy Practices, and cancellation policy and have authorized the release of protected health information, as provided above.

_____ _____

PATIENT SIGNATURE DATE