Bay
2505 Harrison Avenue, Suite C
Panama City, FL 32405
Office: 850.215.9558
Fax: 850.215.9502

Marianna
2928 Daniels Street
Marianna, FL 32446
Office: 850.526.3555
Fax: 850.526.3570

Date ______________________ **(PLEASE PRINT)**

Patient Information

Name ____ Soc. Sec.# ____________
Last Name First Name Initial

Mailing Address ____________________ City ____________ State ______ Zip ______

Physical Address ____________________ City ____________ State ______ Zip ______

Home Phone ( ) ______________ Cell Phone ( ) ______________ Work Phone ( ) ______________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Sex ☐ M ☐ F Age ____ Birthdate ______________ Spouse's Name ______________

Patient Employer ____________________ Occupation ____________ DL# ____________

Business Address ____________________ City ____________ State ______ Zip ______

Whom may we thank for referring you? ________________________________

In case of emergency who should be notified? ____________________ Phone ____________

Parent if patient is a minor ______________________________ Soc. Sec. # ____________

Insurance

Primary

SUBSCRIBER DOB ____________________

Contract # ____________________

Group# ____________________

Relation to Patient ____________________

Address ____________________

City, State, Zip ____________________

Secondary

SUBSCRIBER DOB ____________________

Contract # ____________________

Group# ____________________

Relation to Patient ____________________

Address ____________________

City, State, Zip ____________________

Signature of Responsible Person ________________________________

Rev. 11/09

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BAY FAMILY CARE CENTER NURSING STAFF HAS 48 HOURS, AFTER YOUR REQUEST, TO REFILL ANY PRESCRIPTIONS TO YOUR PHARMACY.

1. **CONSENT FOR TREATMENT:** I authorize the employees and independent physician(s) of Bay Family Care Center to determine what kind of medical treatment and procedures must be done in order to learn more about the patient's condition and what treatment is to be given. Procedures may include x-rays, blood tests, and urinalysis, but not limited to. Further I authorize the patient's staff of Bay Family Care Center to assist in giving, or to give, the test or treatment, which I might receive. I understand Medicine is not an exact science, and acknowledge that no guarantee or assurance has been made to me as to the results of treatments, test or examinations.

2. **PAYMENT:** I hereby ultimately assume all financial responsibilities to pay the cost, for all services provided to me, by Bay Family Care Center, LLC for the care and treatment to me, or on behalf of the patient. In the event of failure to pay balance on account when due, or any installment thereof, the entire amount remaining unpaid on this account shall become immediately due and payable. Further, in the event of such default, the undersigned understands the remaining balance due will be referred to an outside collection agency, and any charges due by the collection agency will be added to my balance.

3. **ASSIGNMENT OF BENEFITS:** I hereby irrevocably assign payment to Bay Family Care Center accepting this assignment of all medical and/or surgical benefits, to include major medical, applicable and otherwise payable to me, by Medicare and other government sponsored programs, private insurance and any other health plan. I understand that I am financially responsible to Bay Family Care Center for charges, which the insurance/third party administrator declines to pay. It is further agreed that any credit balance on accounts by immediate family members and insured may be applied to any balance due to Bay Family Care Center on said accounts. I understand that this assignment will remain in effect until revoked by me in writing.

4. **MISSED APPOINTMENTS:** After three (3) missed appointments, I realize I will be charged a $25.00 fee. I understand that if I do not call 24 hours in advance to cancel/or change an appointment, it will be considered a missed appointment.

I HAVE READ THE ABOVE ACKNOWLEDGEMENT AND FULLY UNDERSTAND THE SAME.

Print Name: ____

Patient Signature: ___________________________________ Date: __________________