SOUND CLINICAL MEDICINE, PS **PATIENT INFORMATION**	TODAY'S DATE:	Patient ID #:
PATIENT INFORMATION: PLEASE PRINT AND ANSWER ALL QUESTIONS: FIRST NAME INITIAL LAST NAME		E-MAIL ADDRESS
ADDRESS	CITY STATE ZIP	HOME PHONE #
DATE OF BIRTH AGE	SEX M◯ F◯ SOCIAL SECURITY #	CELL PHONE #
EMPLOYER		BUSINESS PHONE #
RESPONSIBLE PARTY: PLEASE COMPLETE THIS SECTION IF NOT THE SAME AS ABOVE: FIRST NAME INITIAL LAST NAME		
ADDRESS		HOME PHONE #
EMPLOYER		BUSINESS PHONE #
INSURANCE INFORMATION: INSURANCE CO. PRIMARY	INSURED'S ID#	
INSURED'S NAME	PATIENT'S RELATIONSHIP TO INSURED: SELF◯ SPOUSE◯ CHILD◯ OTHER◯	
INSURED'S ADDRESS	CITY STATE ZIP	HOME PHONE #
INSURED'S POLICY OR GROUP #		
INSURED'S DATE OF BIRTH	SEX M◯ F◯ INSURED'S SOCIAL SECURITY #	
EMPLOYER		BUSINESS PHONE #
INSURANCE CO. *SECONDARY*	INSURED'S ID#	
INSURED'S NAME	PATIENT'S RELATIONSHIP TO INSURED: SELF◯ SPOUSE◯ CHILD◯ OTHER◯	
INSURED'S ADDRESS	CITY STATE ZIP	HOME PHONE #
INSURED'S POLICY OR GROUP #		
INSURED'S DATE OF BIRTH	SEX M◯ F◯ INSURED'S SOCIAL SECURITY #	
EMPLOYER		BUSINESS PHONE #
MEDICAL INFORMATION:	PHARMACY NAME	PHARMACY PHONE #
ALLERGIES TO DRUGS		
SPOUSE'S NAME	CHILDREN (NAME/AGES) SPOUSE'S EMPLOYER	BUSINESS PHONE#
REFERRED BY	EMERGENCY CONTACT (IF OTHER THAN ABOVE)	PHONE #

HIPAA: ACKNOWLEDGEMENT OF RECEIPT/OFFER OF NOTICE OF PRIVACY PRACTICES: Federal law requires us to provide you with a Notice of Privacy Practices, which is our explanation of how we use and disclose your health information, and to ask you to acknowledge that you have received the Notice. You have the right to review our notice before signing this acknowledgement, and if you have any questions, to ask for an explanation of any part of the Notice, or any other aspects of our use and disclosure of your health information. The terms of our Notice may change as the law and our practices change. If we change our Notice, we will have revised copies available to you when you visit us, and also send you a revised copy upon your request. We appreciate you signing this form, which acknowledges that you have received, or have been offered and refused, a copy of our Notice.

SIGNED: _____ DATE: _____

ASSIGNMENT AND RELEASE: I hereby Authorize my Insurance Benefits to be paid directly to Sound Clinical Medicine, PS and I am personally financially responsible for any balance due. I authorize Sound Clinical Medicine and Dr. Michael Wingren to release any information needed to process my insurance claims. I understand that a rebilling charge of 1% monthly (or a $10.00 minimum monthly charge) may be applied to unpaid balance over 30 days past due.

SIGNED: _____ DATE: _____

MEDICARE LIFETIME AUTHORIZATION: I request that payment of authorized Medicare benefits be made to Sound Clinical Medicine, PS for any services furnished me by Dr. Wingren. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

SIGNED: _____ DATE: _____