

Today's Date:					
<b>Patient Information</b>					
Name			Preferred Language		
Address			City, State		Zip code
Home Phone	Cell Phone	Work Phone	Email		
Birth Date	Age	<input type="checkbox"/> Male	<input type="checkbox"/> Female		
Preferred Way to Contact You:					
<input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Email					
*By making a contact selection you are giving us permission to contact you.*					
Employer/School					
Emergency Contact		Relationship		Phone	
How did you hear about us?					
<b>Financial Responsibility</b>					
Person Responsible for Account		Relationship to Patient			
Address		City/State		Zip Code	
Home Phone	Cell Phone	Work Phone	Employer		
Birth Date	SS#	<input type="checkbox"/> Male	<input type="checkbox"/> Female		
<b>Primary Insurance</b>					
Insurance Company		Phone #			
Address		City/State		Zip Code	
Subscriber Name		ID #		Group #	
Birth Date		SS#			
<b>Secondary Insurance</b>					
Insurance Company		Phone #			
Address		City/State		Zip Code	
Subscriber Name		ID #		Group #	
Birth Date		SS#			

Consent to Treatment		
<input type="checkbox"/> I am the patient or	<input type="checkbox"/> I am the parent/guardian of the patient or	<input type="checkbox"/> Other Relationship

I hereby authorize such medical care, treatment, and diagnostic tests as may be recommended and understand there is no warranty or guarantee of result or cure. This consent will remain in effect until I withdraw my consent in writing.

Name

DOB

Reason for Visit

Medical History
Allergies ( Drug , Environmental, Etc.):

Surgeries and Date:


When was your Last:

Mammogram (35 YRS)	Self Breas Exam	Self Testicular Exam

Immunization History:

Diphtheria/Tetanus	Flu Vaccine	Pneumonia Vaccine

Family Medical History (Circle Yes or No) and list family member (Mother, Father, Sibling):

Cancer:	Yes	No	Heart Trouble:	Yes	No
Diabetes:	Yes	No	High Blood Pressure	Yes	No

Have you had any of the following? Circle Yes or No

Y   N   High Blood Pressure	Y   N   Anemia
Y   N   Diabetes	Y   N   Phlebitis
Y   N   Glaucoma	Y   N   Abnormal Bruising
Y   N   Headaches	Y   N   Abnormal Bleeding
Y   N   Eye Disease	Y   N   Cancer
Y   N   Ear Infections	Y   N   Peptic Ulcer Disease
Y   N   Asthma	Y   N   Gallbladder Disease
Y   N   Chest Pain or Angina	Y   N   Hepatitis/Jaundice
Y   N   Shortness of Breath	Y   N   Blood in Stool
Y   N   Excessive Bleeding after Surgery/	Y   N   Hemorrhoids
Y   N   Tooth Extraction	Y   N   Recent Change in Bowl
Y   N   Arthritis	Y   N   Cramping/Pain Abdomen
Y   N   Pneumonia	Y   N   Kidney Trouble/Stones
Y   N   Heart Murmur	Y   N   Thyroid Disease
Y   N   Slow Healing After Cut	Y   N   Sleeping Problems

Y N Convulsions Seizures  
Y N Numbness/Tingling Sensations  
Y N Fainting Spells  
Y N Thirsty More Than Usual  
Y N Considered Suicide

Y N Difficulty Starting Stream  
Y N Prostrate Problems  
Y N Testicle Pain/Swelling  
Y N Blood in Urine  
Y N Other: \_\_\_\_\_

Gynecological:

Date of Last Menstrual Period	Number of Pregnancies
Date of Last Pap Smear	Any Miscarriages

Do you or have you ever smoked? Yes No # of Cigarettes per day \_\_\_\_\_ # Years \_\_\_\_\_

Do you drink alcohol? Yes No # of Drinks per week \_\_\_\_\_

Do you use drugs? Yes No

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_





Thank you for choosing Ancor Health as your health care provider. A patient information sheet and current insurance information is required before seeing the provider. You will be required to follow all registration procedures, which include updating or verifying personal information, presenting verification of current insurance and pay any co-pays or other patient responsibility amount at each visit. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as self-pay patient. As a self-pay patient, Ancor Health's fee is expected to be paid in full at the time of service.

The following are Ancor Health's requirements for payment of medical services:

**Regarding Self Pay for Service Patients**

Ancor Health requires self pay patients to pay the payment in full for the services provided to patients with no insurance. Payments can be made by cash, check, money order, or credit card.

**Regarding Insurance**

Ancor Health will accept assignment of benefits from your primary insurance and one other insurance. A copy of your insurance card(s) is required by our office, and any changes must be brought to our office. If your policy has a deductible or patient responsibility of a co-pay, then you will be required to make that payment at the time of service. Failure to provide our office with current insurance information leads to non-payment from the insurance company and will result in the balance being transferred to patient responsibility.

**Regarding Non-Covered Services**

Please be aware that Medicaid and some insurance companies consider certain services as non-covered services, therefore, you will be expected to pay for these services.

**Regarding Insurance Plans Where We Are a Participating Provider**

All co-pays and deductibles are due prior to treatment.

**Usual and Customary Rates**

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area.

I have read and agree to abide by the terms of this financial policy

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Signature of Parent/Responsible Party

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Date



818 N. Fourth Street  
Longview, TX 75601  
903-236-8600  
903-236-8605 (Fax)

**Non-Sufficient Funds (NSF)**

Ancor Health Center will charge a minimum of \$30.00 for any payment that has been returned as a non-sufficient funds (NSF). Ancor Health Center will notify the responsible party of the non-sufficient fund check by mail. The responsible party has seven business days to pay the non-sufficient fee of \$30.00 to Ancor Health Center. If the non-sufficient fee has not been paid it will be applied to the responsible parties' balance. If a non-sufficient fund has occurred, Ancor Health Center will no longer **accept checks** from the responsible party.

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Print Responsible Party Name

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Date

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Signature of Responsible Party Name



818 N. Fourth Street  
Longview, TX 75601  
903-236-8600  
903-236-8605 (Fax)

**Acknowledgement of Privacy Practices**

I, \_\_\_\_\_ acknowledge that I have read and understand the Notice

of Privacy Practices as given to me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Witness: \_\_\_\_\_

Patient Name: \_\_\_\_\_



818 N. Fourth Street

Longview, TX 75601

903-236-8600

903-236-8605 (Fax)

[www.ancohealth.com](http://www.ancohealth.com)

**Permission to Disclose Relevant Health Information to Friends and Family**

If you desire to have certain family members or other specific people receive your personal protected health information on your behalf, you should provide their information below. We value your privacy and ask that you help us identify the individual's with whom you would like us to discuss your treatment.

Please identify anyone you wish Ancor Health Center to discuss your relevant health information with:

☐ I GIVE PERMISSION for Ancor Health Center to disclose relevant health information (my health status, treatment, and payment arrangements) to my family members and to the individual(s) I have listed below:

Name:

Relationship:

Name:

Relationship:

Name:

Relationship:

Name:

Relationship:

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Printed Name: \_\_\_\_\_

\* Patient is a minor ( \_\_\_\_\_ years of age)\* OR is unable to give permission because:

Signature of Individual Signing on Behalf of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Legal authority to act on the patient's behalf: \_\_\_\_\_

\*\*\*\*\* Office Use Only \*\*\*\*\*

Reviewed by: \_\_\_\_\_



**AUTHORIZATION FOR RELEASE OF RECORDS  
AUTORIZACION PARA EL LANZAMIENTO DE LOS RECORDS**

Previous Doctors Office or Clinic: \_\_\_\_\_  
Anterior Clinica de Doctor: \_\_\_\_\_  
Address/Direccion: \_\_\_\_\_  
Phone/Telefono: \_\_\_\_\_  
Fax: \_\_\_\_\_

To release information to:/ que le de information a:

**Ancor Health Center, PA**

818 N. Fourth St.  
Longview, TX 75601  
(903) 236-8600  
Fax (903) 236-8605

\_\_\_\_\_  
Patient Name (Please Print)/Nombre del paciente

\_\_\_\_\_  
Social Security #/ Numero de Seguridad Social

\_\_\_\_\_  
Date/Fecha

\_\_\_\_\_  
Date of Birth/Fecha de Nacimiento

Circle: Male/Masculino or Female/Femenina

Information to be released: / Information que se puede recibir:

\_\_\_\_\_  
Initial examination/Examinacion Inicial

\_\_\_\_\_  
Discharge Summary/Resumen de la Descarga

\_\_\_\_\_  
Follow-up Care Progress Notes/Notas de Progreso

\_\_\_\_\_  
Office Visit Note/Notas de la Oficina

\_\_\_\_\_  
Specia Procedure Results/Notas de Procedimientos

\_\_\_\_\_  
All Records/Todo El Expediente

The above information is released for the following purpose and that purpose only, and other use is forbidden: Establish Care with **ANCOR HEALTH CARE CENTER**. All medical records regarding treatment, hospitalization and outpatient care for my condition including, but not limited to psychological, psychiatric impairment, drug abuse, alcoholism, AIDS, or HIV antibody testing. This authorization will expire (30) days from the date of my signature or as otherwise specified by date, event, or condition as follows:

Parents Signature/Firma de madre/padre: \_\_\_\_\_

Relationship to Patient/Relacion al paciente: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Date/Fecha: \_\_\_\_\_

Witness/Testigo: \_\_\_\_\_