PATIENT UPDATE

Patient Name
Mailing Address
Home Phone:
Leave a Message: **Yes** ☐ **No** ☐
Date of Birth:
Email Address:

Insurance Information

Primary Insurance:
Subscriber ID:

FINANCIAL OBLIGATIONS

Co-pays:	**All co-pays due at time of check-in. If you have a deductible, $70 for established patients and $110 for new patients, will be due each visit until your deductible is met**.
Insurance Claims:	We require that you disclose all insurance information including: primary, secondary, as well as any change of insurance. Failure to provide complete insurance information may result in non-payment by your insurance, thus you will be responsible for the entire bill.
Outstanding Balances:	**If you are unable to pay your balance in full a payment arrangement must be set up. If you fail to keep your arrangements this may prevent you from scheduling appointments.**

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

By state law you must be advised that: The information authorized for release may include records, which may indicate the presence of a communicable and non-communicable disease, which may include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also known as acquired immune deficiency syndrome (AIDS).

I hereby authorize the physicians and staff of Gilbert Medical Center to release any and all medical records and also consent to having test results mailed for:

Patient Name:

Date of Birth

Social Security Number

Mailing Address:

All information is to be released to: _____

_____

I understand this consent can be revoked at any time, except that disclosure is made in good faith has already occurred in reliance on this consent. Gilbert Medical Center, all employees and officers, and attending physicians are released from legal responsibility or liability for the release of the above requested information.

_____ _____

Patient or Authorized Representative (PRINT NAME) **Signature**

_____

Date

If this form is signed by the patient's authorized representative, please provide a copy of the document (power of attorney, legal guardian) naming the authorized personal representative and provide a description of the personal representative's authority to act on behalf of the patient:

_____