Dr. Kathryn Amacher, DO

PATIENT INFORMATION/ REGISTRATION: Print Legibly

Patient Name: _____

Facility Address:_____

City: _____ **Zip Code**:_____ **Date of Birth**: _____

Circle: Male/ Female **Marital Status**: single/married/widowed/divorced

Does the patient have decision making capacity to handle medical and financial decisions: yes/no

Emergency Contact, Durable Power of attorney for healthcare: _____

Relationship: _____ Phone: _____

Billing Address**:** _____

Alternate Power of attorney/next of kin Name:_____ Phone: _____

Address**:** _____

May we leave a detailed voice message on your phone?: Yes /No **OK to Text:** Yes/No

Do you want access to your electronic medical record online? Yes/No

Email: _____

BILLING INFORMATION, send copy of insurance cards to avoid being billed

Primary Insurance: _____ ID Number: _____

Social Security Number if new 11 digit medicare number unknown: _____

Secondary Insurance: _____ ID Number: _____

Billing Contact (if different than above): Name: _____

Phone: _____Address**:** _____

Please provide a list of all current medications, including supplements

CONSENTS

I consent to a photograph for identification purposes _____ (Initials)
I have read the tele-health policy and agree to tele-health _____ (Initials)
I have read and agree to the Privacy Policy _____ (Initials)

Authorization and Assignment: I herby authorize my insurance carrier, attorney or any third party payer to pay directly to Kathryn Amacher, DO all charges submitted for service incurred by me. I understand I will be responsible for any and all charges not paid by my insurance company. I authorize Kathryn Amacher, DO to release information concerning my medical condition to my insurance, hospital, physicians or attorney for the purpose of processing claim. I assign payment directly to Kathryn Amacher, DO which may be due from Medicare program or any other insurance company, including supplemental insurance, which may cover in whole or in part medical services which I have received. The authorization and assignment shall be valid until I notify Kathryn Amacher, DO in writing the cancellation. A photo copy of authorization shall be as valid as the original copy.

Patient/or DPOASignature: _____ Date: _____