Marchand & Associates
FAMILY MEDICINE

4534 Westgate Blvd., Suite 113 • Austin, TX 78745

PATIENT INFORMATION

Preferred Provider: Dr. _____ Preferred Pharmacy: _____

Patient Name: _____
Last First Middle "Nickname"

DOB: _____ Sex: ____ SSN: _____ Ethnicity (circle one): African American American Indian Asian
Caucasian / White Hawaiian Hispanic / Latino Other

Marital Status: _____ Drivers Lic. # _____ Primary Language: _____

Address: _____
Street Apt # City State Zip Code County

Phone #'s: _____
Home Work Cell/Other Primary

E-Mail Address: _____

Emergency Contact, Relationship to Patient, DOB, Number: _____

Insurance Information: Insurance Company Name: _____

Insurance ID #: _____ Group #: _____

Insurance Claim Address: _____

Policy Holder: _____
Last First Middle Policy Holder's DOB

Address: _____ SAME?
Street Apt # City State Zip Code check here

Phone #: _____
Home Work Cell/Other

SSN: _____ Employer: _____

Payment is due at the time services are rendered. By signing below, you agree to and understand the following policies:

HIPAA – Privacy Notice
I am aware that I may review MAFM HIPAA privacy notice at any time and understand that I may request a copy.

_____
Initials

MAFM Medical Care Agreement
I authorize the physicians of MAFM to administer medical treatment as deemed necessary. I understand that there will be a $25.00 charge for appointments not cancelled 24 hours in advance. I understand that the primary insured is financially responsible for any balance not covered by my insurance including co-pay, deductible/co-insurance, and any services excluded by my policy. I also understand that MAFM will not verify insurance coverage. I also understand the primary insured will be held responsible for any and all charges incurred by myself or covered dependents should there be no coverage on the date of service. Furthermore, I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits to otherwise payable to me to Marchand & Associates Family Medicine.

_____
Initials

Medical Care Agreement

I authorize the physicians of MAFM to instruct their Physician Assistant /Nurse Practitioner and Physical Medicine Providers to assist in certain aspects of my medical care.

I understand that a Physician Assistant/Nurse Practitioner is not a licensed physician and may not treat or diagnose any illness or medical condition except under the supervision/direction of a licensed physician. I understand that each time I make an appointment, if my physician is not available in a timely manner, I will be given the choice to be seen by the Physician Assistant/Nurse Practitioner... I acknowledge that it is my responsibility to inform the staff of MAFM that I wish not to see the Physician Assistant/ Nurse Practitioner and be scheduled with my assigned physician accordingly. I understand that I may revoke this authorization at any time.

_____ _____

Signature Date

How did you hear about us?

☐Word of Mouth ☐Yelp ☐Web Search ☐Facebook ☐Health Grades ☐Community Newsletter ☐Insurance Company _____Other

Gregory Marchand, M.D.