Patient Information: Please print the below information.

CHRISTIE CLINIC
We listen. We care.

Last Name_____First Name_____Middle Initial_____ Maiden_____

Address_____Apt_____City_____State_____Zip_____

Phone Number _____ Employer_____

Date of Birth_____/_____/_____ Sex at Birth: ☐ Male ☐ Female Gender Identity: ☐ Male ☐ Female ☐ Other _____

Primary Care Provider Name _____

Insurance Company Name: _____

Policy/Member ID: _____

Group Number: _____

Insurance Company Phone Number: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Authorization to File/Release Information

I hereby authorize Christie Clinic to release any medical information to my insurance company(s), employer insurance groups, health plans, Medicaid/Medicare program, its insurance carriers or intermediaries, or the Social Security Administration.

Assignment of Benefits: I hereby assign all of my rights and claims for reimbursement under any Medicare, Medicaid, or other insurance policies as set forth above to Christie Clinic for which benefits may be available for payment of services provided.

I permit a copy of this Authorization and Assignment of Benefits to be used in place of the original, and request payment of medical insurance benefits to Christie Clinic. This Authorization and Assignment of Benefits shall be valid and enforceable against any and all of my current and future insurance companies, employer insurance groups, health plans, Medicaid/Medicare program, its insurance carriers or intermediaries UNLESS I notify Christie Clinic in writing of my intention to revoke such Authorization and Assignment of Benefits. The written revocation shall be effective from the date of receipt by Christie Clinic.

IMPORTANT: I acknowledge that I have reviewed and understand my rights and financial responsibilities towards Christie Clinic as indicated in the information provided to me in pamphlet form. I also acknowledge that I have received a copy of Christie Clinic's privacy notice of healthcare information pamphlet. I further acknowledge that I was given ample opportunity and time to ask questions and received answers to my satisfaction.

Signature of Patient or Legal Guardian_____**Date**_____

The Health Information Technology for Economic and Clinical Health (HITECH) Act requires clinics to now obtain the following information. Christie Clinic providers will not use this information in their medical decision making.

Are you Hispanic, Latino/a, or Spanish origin?
- a. ___Hispanic or Latino
- b. ___Not Hispanic or Latino
- c. ___ Prefers not to Report

What is your primary Language?
- a. ___English
- b. ___Other Language (specify) _____
- c. ___Indian (includes Hindi and Tamil)
- d. ___Spanish
- e. ___Russian
- f. ___ Prefers not to Report

What is your race?
- a. ___American Indian
- b. ___Asian
- c. ___Native Hawaiian or Other Pacific Islander
- d. ___Black or African American
- e. ___White
- f. ___Hispanic
- g. ___Other Race
- h. ___Other Pacific Islander
- i. ___ Prefers not to Report