MetroHealth
Multidisciplinary and Integrated Healthcare

Legal Last Name:	Legal First Name:	Middle Name:
Preferred Name:		Social Security Number:
Date of Birth (MM/DD/YYYY):		Gender:
Address:		Unit:
City:	State:	Zip:
Email:		

1. PHONE (HOME | WORK | CELL):

CONFIDENTIAL VOICEMAILS OK?: ☐ Yes ☐ No

2. PHONE (HOME | WORK | CELL):

CONFIDENTIAL VOICEMAILS OK?: ☐ Yes ☐ No

WHERE DO YOU WANT TO RECEIVE APPOINTMENT REMINDERS?:

☐ Email	☐ Phone 1	☐ Phone 2	☐ Text Message

EMERGENCY CONTACT

Name:	Phone number:	Relationship:
Address:		

INSURANCE INFORMATION

DO YOU HAVE HEALTH INSURANCE?

☐ Yes	☐ No	

Primary Insurance:	**Policy number:**	**Group number:**
Subscriber/Relationship:		**Date of birth (if another person):**
Secondary Insurance:	**Policy number:**	**Group number:**
Subscriber/Relationship:		**Date of birth (if another person):**

Time of Service Payment: It is the policy of MetroHealth to collect payment at the time of service. This includes all co-pay amounts, deductibles, private individuals, and sliding fee co-pay. This does not include fees covered by insurance plans in which MetroHealth participates.

By providing my signature below, I certify that the information I have given is correct. I authorize MetroHealth to apply for benefits on my behalf. I request that payment from my insurance company be made directly to MetroHealth.

I clearly understand and agree that I am personally responsible for payment of all services rendered to me. I agree to pay all balances over 90 days from the original due date, as well as court costs and reasonable collection and attorneys' fees, with or without suit, incurred in collecting any past due balance. MetroHealth charges $30.00 for any returned checks.

I authorize the release of any information, including medical information, to my insurance company. This may be necessary to determine and pay insurance benefits to which I am entitled. Either my insurance company or I may revoke this authorization at any time by providing written notice.

Patient Signature: ______________________________ **Date:** ______________

DEMOGRAPHIC INFORMATION

MetroHealth is committed to providing quality care for all patients. We are asking you to provide your marital status; employment status; your racial and ethnic background; and the language you prefer to use when speaking with your provider. Your answers are both voluntary and private. Thank you for your cooperation.

WHAT IS YOUR MARITAL STATUS?

☐ Single	☐ Married	☐ Significant Other	☐ Widowed	☐ Divorced

ARE YOU CURRENTLY EMPLOYED?

☐ Yes, Full Time	☐ Yes, Part Time	☐ No Employee/Address

DO YOU CONSIDER YOURSELF LATINO/A OR HISPANIC? PLEASE CHECK ONE

☐ I am NOT Latino/a or Hispanic	☐ I AM Latino/a or Hispanic	☐ Decline to answer

COUNTRY

WHICH CATEGORY BEST DESCRIBES YOUR RACE? YOU MAY CIRCLE ONE OR MORE:

☐ Black or African American	☐ White or Caucasian	☐ American Indian or Alaskan Native
☐ Asian	☐ Native Hawaiian or Pacific Islander	☐ More Than One Race
☐ Other:__________________		

WHAT IS YOUR PREFERRED LANGUAGE WHEN SPEAKING WITH THE PROVIDER?

☐ English	☐ Spanish	☐ Amharic	☐ Other

DO YOU NEED AN INTERPRETER?

☐ No	☐ Yes	

ADVANCE DIRECTIVES

DO YOU HAVE AN ADVANCE DIRECTIVE?

☐ Yes	☐ No	

If you have an advance medical directive (living will, power of attorney, etc.) please bring in a copy at your next visit.

HOW DID YOU HEAR ABOUT METROHEALTH?

☐ ZocDoc	☐ Friend	☐ Support group
☐ Ad / flyer / website	☐ MetroHealth testing program	☐ Other:__________________
☐ Insurance company	☐ Another agency's testing program	
☐ Referred by medical provider	☐ Community event	

OUR OFFICE POLICIES

Our goal is to provide and maintain a good physician-patient relationship. By informing you in advanced of some of our policies, it allows for good communication and enables us to achieve our goal. Please read each section carefully. If you have any questions, please do not hesitate to ask a member of our team.

PATIENT CANCELLATION AND NO SHOW AGREEMENT

We are glad you have made an appointment for yourself or a family member. To provide you with high-quality care, it is important for you to keep your scheduled appointment with the medical provider.
Valuable time has been reserved for you or your family member. A missed appointment or late cancellation results in lost time that could have been given to another person wanting to receive care.

- Patients arriving more than 10 minutes late to their appointment will be subject to the providers' discretion as to whether they can be seen. Late arrivals may also be subject to an abbreviated visit.
- If a patient cannot be seen, or is more than 15 minutes late for a scheduled visit, it will automatically be considered a no show.

You will receive a reminder call/message ahead to remind you of your appointment; however, it is your responsibility to keep record of your appointment and to arrive on time. If you need to cancel or reschedule your appointment, please call 24 hours in advance (at least one or two business days in advance?). You may also leave a message with our front desk. Every late cancel/no-show will be recorded in your chart. Multiple late cancels and no-shows can end your ability to make advance appointments or receive care at MetroHealth.

INSURANCE PLANS:

1. It is your responsibility to keep our office updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.
2. It is your responsibility to understand your benefit plan with regard to, for instance:
    a. If a written referral or authorization is required to see specialists or if preauthorization is required prior to a procedure.
    b. Some charges may or may not be covered. While the filing of insurance claims is a courtesy that we extend to our patients, not all plans cover all services performed in a medical office. All charges not covered by your plan are your responsibility.

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT

MetroHealth is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement, if possible, that you have received it. If you have questions concerning the management of your healthcare information at our clinic, or if you wish schedule an appointment to view your medical record, please call (206) 638-0750.

Print Name: ______________________________

Patient signature: ______________________________ **Date:** ______________