

Preventive Health Reminder:

Preferred Method of Communication: Postal Mail Phone Web Mail

In order to communicate with us via secure e-mail, please give us your email address and we will extend an invitation to you to activate a secure e-mail account

Patient Information					
Patient Name: Last		First	MI	Phone ()	Cell ()
Address			Birth Date	SS#	
City	State	Zip Code		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced
Emergency Contact		Last	First	MI	Relationship
					Phone () Cell ()
Patient Employer			Occupation	Phone ()	
Address					
City			State	Zip Code	
Spouse Name		Last	First	MI	Phone ()
					Cell ()
Address			Birthdate		
City			State	Zip Code	
Spouse Employer			Occupation	Phone ()	
Address					
City			State	Zip Code	
Language		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Refused to Report			
Race		<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> White <input type="checkbox"/> Black or African American			

<p>Medicare Part B "One Time Authorization Agreement" statement to permit payment of Medicare Benefits to Provider, Physicians, and Patients.</p> <p>"I request that payment of authorized Medicare Benefits be made either to me or on my behalf for any services furnished me by this provider. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its Agents any information needed to determine these benefits for related services."</p> <p>X Payment to Provider</p> <p>X _____ Patients Signature</p>	<p>Authorization for the release of Medical Information and Statement of Financial Responsibility.</p> <p>"I hereby authorize the release of any medical information necessary to process claim(s) for the payment of benefits either to myself or Grand Valley Medical Specialists, PLC."</p> <p>"I further agree to assume financial responsibility for these services and will pay to Grand Valley Medical Specialists, PLC., to the full extent legally due them, any amounts not paid directly to them by Medicare, Blue Shield, or other insurance company."</p> <p>X _____ Patient or Responsible Party Signature</p>
<p>_____ Provider</p>	

ACKNOWLEDGEMENT OF RECEIPT

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she received a copy of the Grand Valley Medical Specialists, PLC, Notice of Privacy Policies on the date indicated below.

Date: _____ Signature: _____ Name of Patient: _____

If this acknowledgment is not signed by the patient, please print the information set forth below:

Name of person signing: _____ Relationship to Patient: _____