clarity

PATIENT INFORMATION FORM

Date

PATIENT INFORMATION

Patient's Last Name | Patient's First Name | Patient's Middle Name | Suffix | Preferred name

Date of Birth

☐ Male ☐ Female

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Another _____

Race: ☐ Caucasian (White) ☐ American Indian ☐ African American (Black) ☐Hispanic ☐ Asian ☐ Multiracial ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Refused/Declined Primary Language: _____

Home address: _____ City: _____ State: _____ Zip: _____

Mail to address: _____ City: _____ State: _____ Zip: _____
(If different from home address)

Home Phone: ( ) _____ ☐ This is the primary number for patient.

Cellphone: ( ) _____ ☐ This is the primary number for patient.

Primary Email Address: _____

EMERGENCY CONTACT (Pediatric Patients, please list someone other than parents/guardians)

Name: _____ Home Phone: ( ) _____ Relation to Patient: _____

PARENT/GUARDIAN INFORMATION (Pediatric patients only)

Parent/Guardian 1 (If the address and/or phone numbers are the same as patient, please indicate same.)

Name: _____ _____ _____ _____
Last | First | Middle | Nickname

Date of birth: _____ Home Phone: ( ) _____ Cell Phone: ( ) _____
Month/Day/Year

Home address: _____ City: _____ State: _____ Zip: _____
(If different from the patient)

Employer: _____ Work Phone: ( ) _____ Ext.

Parent/Guardian 2 (If the address and/or phone numbers are the same as patient, please indicate same.)

Name: _____ _____ _____ _____
Last | First | Middle | Nickname

Date of birth: _____ Home Phone: ( ) _____ Cell Phone: ( ) _____
Month/Day/Year

Home address: _____ City: _____ State: _____ Zip: _____
(If different from the patient)

Employer: Work Phone: ( ) Ext.

RESPONSIBLE PARTY

The Responsible Party is the person who is financially responsible for the patient's account and who will receive all account statements to their address.

Last Name | First Name | Middle Name | Relation to Patient

Home Phone: ( ) _____ Cell Phone: ( ) _____
(If different from the patient) (If different from the patient)

Mail to address: _____ City: _____ State: _____ Zip: _____
(If different from the patient)

Social Security Number:

THIS IS A TWO PAGE FORM

Clarity, Inc. | 29 North Academy Street | Greenville, SC 29601 | PH: 864-331-1400 | FAX: 864-331-1416

Patient Name: _____ (Last) _____ (First) _____ (Middle) Date of Birth: _____ (Month/Day/Year)

☐ **Check here if no insurance. Skip to authorizations (below).**

PRIMARY INSURANCE INFORMATON (Please present insurance card and ID to Business Office)

Subscriber: This is the person who carries the insurance. If the subscriber is the patient, skip to insurance co. name field.

Subscriber's name on card: _____ Subscriber's date of birth: _____ (Month/Day/Year)

Patient relationship to subscriber: _____

If address and phone number is same as patient, please indicate same.

Address: _____ City, State, ZIP: _____ Home Phone: ( )

Insurance co. name: _____ Phone: _____

Policy/Cert #: Group no.: Effective Date:

SECONDARY INSURANCE INFORMATON (Please present insurance card and ID to Business Office)

Subscriber: This is the person who carries the insurance. If the subscriber is the patient, skip to insurance co. name field.

Subscriber's name on card: _____ Subscriber's date of birth: _____ (Month/Day/Year)

Patient relationship to subscriber: _____

If address and phone number is same as patient, please indicate same.

Address: _____ City, State, ZIP: _____ Home Phone: ( )

Insurance co. name: _____ Phone: _____

Policy/Cert #: Group no.: Effective Date:

AUTHORIZATIONS

I authorize evaluation and treatment and I authorize release of information for insurance/medical purposes concerning evaluation and/or treatment serivces provided to me by Clarity, Inc. I hereby also authorize payment from my insurance company to Clarity, Inc. for services rendered. In addition, I authorize audio recording for the purpose of accurate scoring during the provision of evaluation services.

Signature _____ Relation to Patient _____ Date _____

ACCEPTANCE OF PAYMENT POLICIES AND FINANCIAL RESPONSIBILITY

I understand that some services provided by Clarity, Inc. may not be covered by my insurance and that I will be responsible for any amount not covered by my insurance at the time of service. I understand that it is my responsibility to notify Clarity, Inc. if my insuranve coverage changes and that I will be financially responsible for any noncovered services. I understand that Clarity, Inc. will collect all applicable copays, deductibles, coinsurance, and fees for services not covered by my insurance at the time services are rendered.

If a deposit is required for scheduled services I understand that if I cancel the appointment(s) within (2) weeks of the appointment(s) and choose not to reschedule the appointment(s), the deposit will be forfeited. This policy does not apply to appointments that must be rescheduled due to illness or family emergency. I further acknowledge that only one reschedule will be allowed before my deposit is forfeited (this does not apply if Clarity, Inc. has to reschedule the appointment).

Signature _____ Relation to Patient _____ Date _____

LATE CANCELLATION AND NO-SHOW POLICY

*I understand that if for any reason I am unable to keep a scheduled appointment, I must contact Clarity at least 24 hours in advance at **(864) 331-1400** to cancel or reschedule. If **two** appointments (in any six-month period) are missed or cancelled with less than 24 hours' notice, Clarity will reschedule the appointment **after** a six-month waiting period from the time of the missed appointment.*

Signature _____ Relation to Patient _____ Date _____

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