Imperial Center Family Medicine
4309 Emperor Blvd., Suite 125
Durham, NC 27703
Phone (919) 941-0158 Fax (919) 474-3130

PLEASE PRINT

Name: _____ Sex _____ Date of Birth _____ Martial Status _____
First MI Last
SS# _____ Preferred Physician/PA_____ Home Address _____

City _____State_____**Zip** _____ Home PH ( ) _____ Work PH ( ) _____Cell ( ) _____

Email Address _____ Employer _____Occupation _____

Work Address _____ City _____ State _____ Zip _____

Medical Insurance (primary cardholder) Information. Complete if other than patient.

Name _____ SS# _____ Relationship to Patient _____
First MI Last
Sex _____ Date of Birth _____ Employer _____

Guarantor: Person responsible for medical expenses after insurance payment for (minor/student) Patient.

Name _____ Date of Birth _____ Address _____
First MI Last
City _____ State _____ Zip _____

Patient Consent
I hereby give my permission/consent for Dr. Jacokes/Torrey and staff to treat me using generally accepted standards of medical care. I am aware that medicine and surgery are not exact sciences and no guarantee for successful outcome has been made or implied to me. I understand that treatment for my condition(s) will be based upon the information that I provide. I accept full responsibility should I provide inaccurate, incomplete, or misleading information. I certify that the IDENTIFYING INFORMATION, ADDRESSES AND TELEPHONE INFORMATION, I have provided is correct and agree to inform Dr. Jacokes/Torrey and staff if information changes/becomes outdated. I understand that Dr. Jacokes/Torrey and staff cannot contact me if I have provided incorrect or illegible information, or if information is not kept current and correct.

Authorization to Release Patient Records to Insurer
I hereby authorize Dr. Jacokes/Torrey and staff to release any and all records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses for care provided by Dr. Jacokes/Torrey and staff as is required by North Carolina Insurance Regulations. I understand that this authorization allows Dr. Jacokes/Torrey and staff to release to my insurer or financial payer any information concerning me, including but not limited to confidential information, financial records, and the records of any treatment or examination rendered me. I understand that this release, and any future general release that I may sign, specifically allows for the release of information to my insurer or financial payer concerning HIV test results and/or related data that may be a part of my medical records. This general release and authorization shall remain in effect until revoked by me in writing.

Assignment of Benefits
To Third-Party Payer/Insurance Carrier/Supplemental Insurance.
In consideration of service rendered by Dr. Jacokes/Torrey their agents and staff, I hereby assign Dr. Jacokes/Torrey the benefits due to me under my health insurance plan. I agree that I shall be responsible for all portions of payments due to Dr. Jacokes/Torrey for services received that are not covered by the above such as annual deductible, co-payments, and co-insurance. I agree that I shall be solely responsible for the entire bill for services or any balance thereof that may be determined to be not covered by my health plan. This assignment of benefits shall remain in effect, even if my insurance carrier changes, until revoked in writing.

I have read, understood and agree to the above. The information, which I have provided, is true and complete to the best of my knowledge.

_____ _____ _____
PRINT Name Signature Date

_____ _____ _____
PRINT Parent or Guardian Signature Parent or Guardian Date