LCFP
Lake County Family Practice
Lake Ambulatory Care Center
9500 Mentor Avenue, Suite 100
Mentor, Ohio 44060

Referred by _____

Date:		Primary Care Physician:	
PATIENT			
First Name	Middle Initial	Last Name	
SSN	□Single □Married □Divorced □Separated □Widowed		Sex □ male □ female
Date of Birth	Employer	□ Full-time □ Part-time	Employer Telephone
Patient Mailing Address			
City		State	Zip
Home Telephone	Cell Phone	E-Mail Address	
RESPONSIBLE PARTY □ Check if PATIENT is same as Responsible party and go to Emergency Contact			
First Name	Middle Initial	Last Name	
SSN	Title		Sex □ male □ female
Date of Birth	Employer	□ Full-time □ Part-time	Employer Telephone
Responsible Party Mailing Address			
City		State	Zip
Home Telephone	Work Telephone	Relationship To Patient	
NAME OF RELATIVE/FRIEND IN CASE OF EMERGENCY			
Name		Relationship To Patient	
Home Telephone	Alternate Phone Number		

PRIMARY INSURANCE			
Insurance Card Holder First Nome	Last Name	Date of Birth	Relationship to Patient
Insurance Company Name	Insurance ID Number	Employer Phone Number	
SECONDARY INSURANCE			
Insurance Card Holder First Name	Last Name	Date of Birth	Relationship to Patient
Insurance Company Name	Insurance ID Number	Employer Phone Number	

CHILDREN/FAMILY

NAME	Date of Birth	NAME	Date of Birth
1) _____	___/___/_____	4) _____	___/___/_____
2) _____	___/___/_____	5) _____	___/___/_____
3) _____	___/___/_____	6) _____	___/___/_____

If necessary, how may we contact you? Preferred for confirming appointments HOME WORK CELL

Home (_____) - _____ - _____ Work (_____) - _____ - _____

Cell (_____) - _____ - _____

May we leave a message? Yes ☐ No ☐ Answering Machine: ☐ Yes ☐ No

REQUEST FOR GENERAL TREATMENT

I request and authorize Lake Health Inc., its employees, my physician. and allied health professionals as are necessary to provide care. Further, I authorize my physician to permit the presence of observers in my treatment as deemed necessary.

I, _____, understand and acknowledge that from time to time. medical students. nursing students or students of other healthcare disciplines may be undergoing clinical education in Lake Health. I hereby authorize and permit such students of any such health profession to participate in my care in so far as they are properly supervised at all times by a licensed and credentialed healthcare practitioner in that field of expertise. I acknowledge that I have a right to ask questions of any physician or nurse regarding the use of students in my care at any time.

X _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION (Insurance/Medicare Beneficiaries)

I authorize Lake Health Inc. to release any medical records or medical information necessary to file an insurance claim, to perform quality and utilization assessments, and to release any medical information which may be requested by my insurance carrier or agencies on their behalf. I authorize release of medical information to a quality assurance of peer review committee or organization, and compliance audits.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge. I am responsible only for the deductible, coinsurance, and non covered services.

I HAVE REVIEWED AND CONSENT TO ALL APPLICABLE CLAUSES BY SIGNING BELOW. I UNDERSTAND THE NATURE OF THIS CONSENT AND IT IS REVOCABLE AT ANY TIME.

Signature X_____ Relationship to Patient_____

Witness to above signature:_____ Date:_____ /_____ / _____

Medicare Received:_____ Date: _____ /_____ / _____
Signature

Privacy Notice Received: _____ Date: _____ /_____ / _____
Signature