Annual Demographic Update Form

☐ ***Driver License*** ☐ ***Insurance Card2022***

Full Name:	DOB:	Marital Status:	
Full Address:	City:	State:	Zip:
Sexual Assignment At Birth:	Gender Identity:	Sexual Orientation:	
Home Phone:	Cell Phone:	Daytime Phone (Mon-Fri)	
SSN: **required**	Emergency Contact:		
Employer/School	Emergency Contact Phone:		
Work Phone:	Relationship to Contact		
Email Address (this is needed for our patient portal):			

I give my permission to Nature Coast Health Care to release information regarding my protected health information to the following.
If you DO NOT want anyone listed, please write **NO ONE**
_____, _____, _____, _____

I,_____ give Nature Coast Health Care permission to leave **detailed clinical** information on my voicemail
at only the number provided (____)-_____-_____
Patient Signature _____ Date _____

*****(PLEASE CIRCLE ONE)**
RACE: Native American, Indian, Alaskan Native, Asian, African American, Caucasian, Refused to Report, Other:_____
ETHNICITY: Hispanic or Latino, Non-Hispanic or Latino, Refused to report, Other:_____
LANGUAGE: English, Spanish, Refused to report, Other:_____

******DO YOU HAVE A LIVING WILL? ____YES ____NO*****

Primary Insurance		
Insurance Company:	Policyholder ID#:	
Policyholder's Name:	Group #:	
Relationship to Policyholder:	Policyholder's DOB:	
Secondary Insurance		
Insurance Company:	Policyholder ID#:	
Policyholder's Name:	Group #:	
Relationship to Policyholder:	Policyholder's DOB:	

Authorization/Assignment/Financial Responsibility

1. If your insurance requires a specified primary care physician or PCP, then you must have Nature Coast Health Care designated as your PCP prior to your appointment.
2. We automatically file all insurance as a courtesy to you. However, our office cannot accept responsibility for negotiation of claims with insurance companies or other parties. If you have any questions concerning your coverage and/or covered services, please contact your insurance company. **We cannot determine what your plan coverage involves. It is the patient's responsibility to find out if our office participates with their insurance plan and what the policy covers. If we do not participate with your insurance, it is in the best interest of the patient to find another provider. Our policy will not allow patients to be self-pay in this situation. You may reestablish with our office if an insurance is selected that we are contracted with.**
3. We file insurance claims electronically by computer and on paper; your signature at the bottom of this page gives us permission to do so.
4. **Contract To Pay for Medical Services**: I have read, and I understand the above office policy concerning my insurance. I understand that I am fully responsible for payment of professional services rendered to me by Family Care Physicians. If insurance is filed for me, I authorize release of information to my insurance carrier, as well as direct payment of benefits to Nature Coast Health Care for the services rendered.
5. **You are responsible for all copays, co-insurance and deductibles at time of office visit.**

Guarantor (Patient) Signature: _____ **Date:** _____

Patient Name: _____ **Date:** _____