Coastal Senior Healthcare, Inc.
3914 E State Road 64
Bradenton, FL 34208

Phone: 941-216-3800 Fax: 941-216-3703

START OF CARE DATE

Patient Last Name | Patient First Name | Date of Birth | M F | Social Security Number

Location/Facility | Facility Phone #

☐ Single ☐ Married ☐ Widow ☐ Divorced

Address | Apt # | City | State | Zip Code

Emergency Contact Name | Relationship to Patient / POA? | Emergency Telephone Number

Address | Apt # | City | State | Zip Code

Email address

INSURANCE INFORMATION

Name of Primary Insurance Company | Policy Number | Group Number | Phone Number

Name of Secondary Insurance Company | Policy Number | Group Number | Phone #

Subscribers Name | Relationship to Patient

Responsible Party's Address, City State, Zip | Home Phone Number | Cell Phone Number

Authorization and Consent to Treat

- I hereby authorize Coastal Senior Healthcare, Inc. to provide services and treatment for my medical condition.
- I also consent and authorize representatives/employees of Coastal Senior Healthcare, Inc. to provide timely and appropriate medical care services in the home setting.
- I understand that the provider from Coastal Senior Healthcare will be acting as my primary care provider and will therefore be billing for Chronic Care Management, and Behavioral Health Integration as part of my care.
- I understand and accept responsibility of participating and cooperating in my care and acknowledge that no guarantee regarding the results of services to be provided is made.
- I understand that all representatives/employees will be adequately experienced, licensed health care professionals.
- I reserve the right to refuse services or treatment at any time upon giving verbal notification to the practice or service team member. Furthermore, I understand the practice reserves the right at all times to cease providing services to me in my home upon verbal or written notification stating reasons of same.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read it if I so chose) and understood the notice. I understand that a signed copy of this signature page will be placed in my chart to reflect that I have received the entire notice. I authorize the release and discussion of patient information with: _____

Medical Records Release

I hereby authorize the release of my confidential health record and any pertinent information including mental health, drug & alcohol abuse, genetic testing, HIV/AIDS or STD records. I hereby authorize the disclosure of my medical and insurance information to this office for the purpose of my care or to ensure payment from the insurance company. I hereby assign insurance payments directly to this office otherwise payable to the insured. I understand that I am financially responsible for all charges whether paid by my insurance or not. I agree to allow a copy of this authorization to be used in place of an original.

_____

Signature of Patient\POA\Guardian: _____ **Date:** _____