EQUALITY
CARE CENTER™

4220 North 20th Avenue Phoenix, AZ 85015
3306 W. Roosevelt St. Phoenix, AZ 85009

Chart #: _____

PATIENT INFORMATION & INSURANCE

Patient Information

Patient Name: _____ Date of Birth: _____ Date: _____

Social Security: _____ Sex: ☐ Male ☐ Female

Main Phone: ( ) _____ Other: ( ) _____

Address: _____ City: _____ State: _____ Zip: _____

Marital Status: _____ Spouse's Name: _____

Race/Ethnicity:

☐ African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ White ☐ Asian ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Preferred Language: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Primary Insurance:

Insurance Company: _____ Policy Holder Name: _____

SS#: _____ DOB: _____ Relationship to Patient: _____

Policy Number: _____ Group #: _____ Benefits Number : ( ) _____

Secondary Insurance:

Insurance Company: _____ Policy Holder Name: _____

SS#: _____ DOB: _____ Relationship to Patient: _____

Policy Number: _____ Group #: _____ Benefits Number : ( ) _____

Insurance Authorization:

I hereby authorize Equality Care Center to furnish information to my insurance carriers concerning my illness and treatment.

Assignment of Benefits:

I hereby assign to Equality Care Center all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance.

Treatment Authorization:

I hereby authorize Equality Care Center to render healthcare services to my dependents or myself.

Authorization for Electronic Communications:

I hereby authorize Equality Care Center to communicate with me by email or text messaging for my appointments and/or treatment. I am aware that electronic communications may not be secure.

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Insurance Co-payments, Deductibles, and Co-insurance:
I understand that all co-pays, deductibles, and co-insurance amounts are due at the time of service. It may be necessary to re-schedule my appointment if my co-payment, deductible and/or co-insurance are not satisfied.

Changes to My Insurance:
I must notify Equality Care Center immediately of any new insurance or changes to my current insurance. Any cost incurred by this office as a result of receiving incorrect and/or not up to date information by me are my responsibility.

Late Cancel, Cancellations, No Shows:
Equality Care Center requires 24 hours' notice for canceling your appointment. When scheduling we ask that you be courteous to all those individuals who need access to medical care in a timely manner. Equality Care Center wants to assist you in staying compliant with your treatment plan and providing you with appointments in a timely manner.

Patient Rights:
I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

Patient Signature:_____ **Date:**_____ **ECC** Witness: _____