



Healing Arts

Community Health Center
of Blanco and Canyon Lake



Welcome! Please complete the following information -

Patient Information

First Name _____ Initial _____ Last _____
 Date of Birth _____ Gender _____ Social Security _____ Marital Status _____
 Home (_____) _____ Work (_____) _____ Cell (_____) _____
 Address _____ City _____ State _____ Zip _____
 Email _____ Employer _____

Guarantor / Policy Holder Information (if other than patient)

First Name _____ Initial _____ Last _____
 Date of Birth _____ Gender _____ Social Security _____ Marital Status _____
 Home (_____) _____ Work (_____) _____ Cell (_____) _____
 Address _____ City _____ State _____ Zip _____

Insurance Information

Please present insurance card(s)

Primary Insurance Co. _____ Policy Holder _____
 Secondary Insurance Co. _____ Policy Holder _____

Emergency Contact

Name _____ Relationship _____ Phone (_____) _____

Release of Information

I authorize my current insurance company to pay medical benefits to Healing Arts Community Health Center. I (or my guarantor) agree to pay for any uncovered fees. I authorize the release of medical information necessary to process my medical claims.

Signature: _____ Date: _____

Medicare Patients

I request that authorized Medicare payments be made to Healing Arts Community Health Center. I (or the guarantor) agree to pay for any uncovered fees. I authorize the release of medical information to HCFA to determine benefits and to process my medical claims.

Signature: _____ Date: _____

All Patients

I have been provided an opportunity to review the HIPAA Notice of Privacy Practices. Date _____

Patient Signature (Guarantor if patient is a minor): Signature: _____