

## **New Patient Demographic Form**

Do NOT complete this page if you have previously provided this information to Columbia Doctors.

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Sand me an invitation to join myColumbiaDoctors	brochure for details.	
Look for your email invite to register from norenly@followmyhealth organd click the		

Updated: 7/29/2014



·	Pharmad	spaces below: Location cy Phone:	Date (	of last visit / / / /
Name Phone Primary Care Psychiatrist Psychotherapist Dentist  Preferred Pharmacy:	Pharmad	Location	Date (	of last visit / / / /
Primary Care Psychiatrist Psychotherapist Dentist  Preferred Pharmacy:		cy Phone:	/ / /	/ / /
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Collection of the following information is encouraged a monitor and improve the quality of care provided to al Ethnicity:  Race:	•	n agencies. This info	ormation	is used to
□ Decline Response □ Decline Response		Native Hawaiian o	r Pacific	Islander
□ Hispanic or Latino □ American-Indian or A	Alaska Native 🛚	White		
□ Not Hispanic or Latino □ Asian		Other		
<ul> <li>Black or African Ame</li> </ul>	rican			
Preferred Language:		Decline Response		
Patient Signature:		Date:		
Patient Financial Obligation Agreement				
I agree to be financially responsible and make full payr	nent for service	s upon check-in for	each visi	it. I
understand that the Clinic for Anxiety and Related Disc	orders does not	accept insurance, a	nd I auth	orize
Columbia Doctors to release pertinent medical informa	tion to my insur	ance company whe	n reque	sted or to
facilitate payment of a claim.				
Patient or Guarantor Name (Print):				
Patient or Guarantor Signature:		Date:		
Notice of Privacy Practices: Acknowledgement of Rec	eipt			
I acknowledge that I was provided with a copy of the C	olumbiaDoctors	Notice of Privacy P	ractices.	
Patient Name (Print):				
Patient Signature:		Date:		
If completed by a patient's personal representative, pl	ease print and s	ign below.		
Representative (Print):		Relationship:		
Representative Signature:		Date:		

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