ALLIANCE
Family Care, LLC
Extended Hours Medical Clinic
We're there when you need us.

Please fill out this form completely and accurately. All information provided is confidential and protected by HIPAA regulations.

Patient Information

Field	Value
Full Name	
Date of Birth	
Address	
City	
State	
Zip Code	
Phone Number	
Email Address	

Field	Value
Emergency Contact Name	
Emergency Contact Phone Number	

Medical History

Please list any current medications, allergies, or medical conditions.

- Medications:
- Allergies:
- Medical Conditions:

Have you had any surgeries or hospitalizations in the past? If yes, please describe.

Insurance Information

Field	Value
Primary Insurance Company	
Primary Policy Number	
Primary Group Number	

Secondary Insurance Information (if applicable)

Field	Value
Secondary Insurance Company	
Secondary Policy Number	
Secondary Group Number	

Consent to Treat

I hereby authorize Alliance Family Care LLC, and its staff to provide medical treatment and care as deemed necessary. I understand that this may include examinations, tests, procedures, and other medical services. I acknowledge that I have been given the opportunity to ask questions about my treatment and care, and all questions have been answered to my satisfaction.

I understand that the practice will bill my insurance company. I am ultimately responsible for payment.

Medicare Patients Only: Chronic Care Management Consent Form

I understand that Alliance Family Care LLC offers Chronic Care Management (CCM) services for Medicare patients with multiple chronic conditions. These services include, but are not limited to:

- Development and revision of a comprehensive care plan.
- Care coordination between specialists, hospitals, and other healthcare providers.
- Medication reconciliation and management.
- Regular check-ins and monitoring of health status.

I acknowledge that by consenting to CCM services, Only if I have secondary insurance, there would be no copay. I understand that I have the right to revoke this consent at any time by notifying Alliance Family Care LLC in writing.

I authorize Alliance Family Care LLC and its staff to provide and coordinate my chronic care management.

Signature:

Date:

Acknowledgement

I certify that the above information is true and correct to the best of my knowledge.

Signature:

Date: