Highland Primary Care

513 Lauchwood Drive
Laurinburg NC 28352
P: (910) 506-4510
F: (910) 506-4527

9241 Morgan Street
Laurel Hill NC 28351
P: (910) 462-4624
F: (910) 462-4627

PATIENT INFORMATION	
Preferred Provider: ______ Donna _____ Mary	Preferred Office Location: _____ Laurinburg _____ Laurel Hill

Last Name:	First Name:	MI	Maiden:
Street Address:		City/State/Zip:	
Home #:	Cell #:	Work #:	Preferred #:
Date of Birth:_______/______/_______ Gender: Male Female	Soc.Sec.#: ________-______-______	Marital Status: Single Married Separated Divorced Widowed	
Race: White Black Am. Indian Hispanic Asian Other:_______________		Ethnicity: Hispanic Not Hispanic	
Employer Name:		Text: Y N	Voice Message: Y N
Emergency Contact Name:		Preferred Language: English Spanish Sign Language Other:___________	
Em. Contact #:		Relationship to Patient:	
Next of Kin Contact Name:		Relationship to Patient:	
Next of Kin Contact #:		Family Physician:	
Patient email:		Referred By: Internet Friend Family Dr:___________ Hospital:_______________	
Patient Preferred Pharmacy (Name and Location):			

RESPONSIBLE PARTY/GUARANTOR If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor.

Last Name:	First Name:	MI:	Maiden:
Street Address:		City/State/Zip	
Date of Birth:____/____/_____	Soc.Sec.#: _______-_____-______	Relationship to Patient:	

PRIMARY MEDICAL INSURANCE	SECONDARY MEDICAL INSURANCE
Insurance Co. Name:	Insurance Co. Name:
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Soc.Sec. #:	Policy Holder's Soc.Sec. #:
Member/Subscriber ID #:	Member/Subscriber ID #:
Group #:	Group #:

I certify that I have read and agree to Highland Primary Care's (HPC) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to HPC all money to which I am entitled for medical expenses related to the services performed from time to time by HPC, but not to exceed my indebtedness to HPC. I authorize HPC to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $30.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from HPC by text or email at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such emails and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to HPC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Highland Primary Care's Privacy Notices. _________ (Initials)

Signature of Responsible Party: ____ Date: ________________________

Printed Name of Signature Party: ____ Date: ________________________

Revised: 8/2023