Debbie Meyers CNP, MS
Maureen Goldman CNP, BCB-PMD

72 Suttle Street, Suite C
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Phone (970) 403-8812
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New Patient Information Sheet

(Please Print Clearly)

Name: ____

Mailing Address : ____

City : _____________________________________ State : ________________ Zipcode : ___________________

DOB: __________________ Age: __________ Sex (circle) F M Marital Status (circle): S M Other ________

Home Phone : ___________________________________ Cell Phone : __________________________________

Social Security Number:______________________________ Email : ____________________________________

Employer :____ Phone: __________________________

Emergency Contact : ____ Phone: __________________________

Insurance Company: ____ Phone: __________________________

Claims Address : __________________________________ City : ________________State : _______ Zip : _______

Insured/Subscriber Name: _______________________________________ Subscriber DOB : _________________

Subscriber Number : __________________________________ Group Number _____________________

Relationship to Patient (circle): Self Spouse Other: __________________________________

Please Read and Sign

I understand and authorize payment of all medical benefits to be paid directly to Sage Health Care, LLC / Deborah Meyers CNP, MS (owner). I hereby authorize Sage Health Care, LLC to release/furnish any medical information necessary for insurance claims. The patient/responsible party is personally and fully responsible for payment of any balance not paid by their insurance within 45 days of billing.

____ ________________________________

Signature of Patient of Legal Guardian Date

With Debbie Meyers CNP, MS
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Acknowledgement of Notice of Privacy Practices

To Respect Your Privacy:

With my consent, Sage Health Care, LLC may communicate with me regarding appointments, reminders, test results, and other health concerns in the following ways:

____________ Call my home

____________ Call my work

____________ Call my cell phone

____________ Communicate via e-mail

____________ Mail my home/ P.O. Box

____________ Fax to: ________________________

I, ____ hereby read and acknowledge that I have been presented with a copy of Sage Health Care, LLC Notice of Privacy Practices.

____ ______________________
Signature of Patient Date