**Patient Information: (Please fill out every field completely. Circle Items in blue**)

|  |  |  |  |
| --- | --- | --- | --- |
| First Name and M.I. |  | I II III IV V | Other: |
| Last Name |  | Jr Sr |
| Mailing Address |  | Date of Birth: |
| Address line 2 |  |  |
| City, State |  | Phone Number: |
| Zip Code |  |  |
| Sex: M F |  | Relationship to patient: |
| Email Address |  | Self Parent Spouse Guardian |

Insurance information

(Disregard fields if they are completed above)

|  |  |
| --- | --- |
| Insurance Name: | Insurance Phone: |
| Subscriber name: | Subscriber DOB: |
| Member ID: |
| Group Name/Employer: | Group ID Number: |
| Relationship to Subscriber: Self Spouse Child Other: |
| Concerns/Questions: |
|  |
|  |

I authorize release of my information in the event of an emergency to the following person: (If none, leave blank)

|  |  |
| --- | --- |
| Emergency Contact Name: |  |
| Emergency Contact Phone: |  |
| Any Restrictions: |  |
| Relationship: |  |

Signature\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of patient/responsible party)

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient \_\_\_\_\_\_\_\_

*\*If the patient is unable to sign this agreement or is a minor, I am entering into the agreement on behalf of and as the legally authorized representative of the patient. The appropriate paperwork has been given by the patient to the Clinic.*

**HIPPA PROTECTED HEALTH INFORMATION – ACCESS FORM**

I understand that stated and federal laws permit HALLSVILLE MEDICAL CLINIC to share Protected Health Information), with the persons involved in my care or the payment of my health care services. I further understand that I have (i) the right to grant certain persons access to my PHI and (ii) the opportunity to restrict access to my PHI from certain persons who might otherwise have access. I understand that granting access DOES NOT give the person access to copies of my medical records.

Access: I grant permission for the following persons to have access to my Protected Health Information.

NAMES (please print) DOB Phone Number

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

I understand that I may change or revoke this form at any time by contacting the Health Information Management Department (directly forwarded to the Business Office Administrator) at the Hallsville Medical Clinic office location. I understand that such changes or revocation will not be effective for disclosures that have already been made or access which has already occurred based on this form.

YES or NO You may leave confidential clinical information on my answering machine/voicemail.

Signature\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of patient/responsible party)

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient \_\_\_\_\_\_\_\_

*\*If the patient is unable to sign this agreement or is a minor, I am entering into the agreement on behalf of and as the legally authorized representative of the patient. The appropriate paperwork has been given by the patient to the Clinic.*

***CONSENTS AND AGREEMENTS SIGNATURE***

 *I understand that the following packets of paperwork were made available to me to review before and at my initial new patient visit. My signature below indicates my authorization of these policies IN REGARDs TO my medical treatment. I can request a copy of any/all of these documents at any time, and I am aware they are also available for review on* [*www.hallsvillemedicalclinic.com*](http://www.hallsvillemedicalclinic.com)

* Patient Consent – (GIVING CONSENT TO RECEIVE TREATMENT AT THE CLINIC LOCATION, RELEASE/ACQUISITION OF INFORMATION, HEALTH INFORMATION EXCHANGE, HIPPA NOTICE OF PRIVACY PRACTICES)
* Patient Authorization – (assignment OF BENEFITS, FINANCIAL responsibility, AUTOMATED COMMUNICATIONS, OUTPATIENT DEPARTMENT)
* Financial Policy – (AGREEMENT OF FINANCIAL responsibility, THE CLINIC’S RIGHT TO COLLECT PAYMENT FOR SERVICES, AND TO BILL INSURANCE IF ALLOWABLE)
* CLINIC CARE CONSENT – (GENERAL CONSENT, PERSONAL PROPERTY, RIGHTS AND ADVANCE DIRECTIVES, FINANCIAL ASSISTANCE, RELEASE OF INFORMATION, MEDICARE/MEDICAID BENEFITS, COMMUNICATIONS, ACCIDENTAL EXPOSURE AND STATE REPORTING, OWNERSHIP, PHOTOGRAPHY, ETHICS, TEACHING AND OBSERVATION, NOTICE OF PRIVACY PRACTICES, DIRECTORY, ASSIGNMENT OF BENEFITS, INSURANCE NETWORK, BALANCE BILLING DISCLOSURES)

(Requests for these documents can be made by email to hmc@hallsvillemedicalclinic.com or in person)

**ACKNOWLEDGEMENT:** By signing below, I certify that I have read this document, understand its contents and agree to the terms. I acknowledge that I am the patient, or I am the patient’s legally authorized representative and/or Guarantor. A photocopy or a faxed copy of this consent shall be deemed as valid as the original.

Signature\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of patient/responsible party)

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient \_\_\_\_\_\_\_\_

*\*If the patient is unable to sign this agreement or is a minor, I am entering into the agreement on behalf of and as the legally authorized representative of the patient. The appropriate paperwork has been given by the patient to the Clinic.*

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