MMH FAMILY HEALTH CLINIC

INSURANCE INFORMATION

WE FILE MEDICARE, MEDICARE SECONDARY, SUCH AS AARP, UNIVERSAL, ETC., MEDICAID, AND MOST PRIVATE INSURANCES. We request copay payment at the time of service on all private insurances and will give you a super bill with diagnosis and paid charges for you to file with your insurance company if you wish. We are on some PPO programs and are trying to incorporate more into our practice. Please ask if we are on your particular program.

If you have your insurance cards with you, we will photo copy them and you will not have to fill out this paper. PLEASE READ AND SIGN THE BOTTOM OF THIS PAGE.

INSURANCE COMPANY: _____

INSURANCE ADDRESS: _____

INSURANCE PHONE #: _____

NAMED OF INSURED: _____

RELATIONSHIP TO YOU: _____ SS# OF INSURED: _____

ADDRESS OF INSURED: _____

GROUP INSURANCE #: _____ POLICY #: _____

IS YOUR INSURANCE THROUGH YOUR EMPLOYER? _____ PERSONAL PLAN: _____

EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____

EMPLOYER'S PHONE: _____

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ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to MMH Family Health Clinic for services rendered.

SIGNATURE: X _____ DATE: X _____

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RELEASE OF INFORMATION: I authorize the release of any medical information necessary for the processing of any claims.

SIGNATURE: X _____ DATE: X _____

MMH FAMILY HEALTH CLINIC
CONSENT TO TREAT

AUTHORIZATION OF CARE

I authorize the staff of the MMH Family Health Clinic (MMH FHC) to render medical/surgical treatment, examinations, diagnostic procedures, or clinical services prescribed by the medical staff, their assistants, or their designees as necessary in the medical staff's judgment.

DISCLOSURE OF REQUIRED HIV/AIDS TESTING

Texas law authorizes a physician to require that a patient be tested for possible exposure to the Human Immunodeficiency Virus, the virus associated with AIDS, in the following situations: (1) if a health care worker is accidentally exposed to a patient's blood or body fluids, such as through a needlestick; or (2) if a medical or surgical procedure is to be performed with could expose health care workers to the patient's blood or body fluids. This disclosure is to inform you that you may be tested if any of these situations occur while in our office.

LAB/DIAGNOSTIC SERVICES

I understand that I may receive a separate bill if my medical care includes services which need to be sent to the Muenster Memorial Hospital. This is to include any co-pay or balance due for these services.

Patient Name:X_____ DOB:X_____

Signature:X_____ Date:X_____

If patient is a minor or patient is unable to sign or give consent:

Responsible Party Name:_____

Responsible Party Signature:_____ Date:_____

☐ Parent ☐ Guardian ☐ Spouse ☐ Other _____