Z MEDICAL CENTER INC

Patient Information Sheet

YOU MUST FILL OUT EVERY LINE ON THIS SHEET!!

Please print all information and use legal name printed on your insurance card.

Who is responsible for patient Self Parent Other______________ How did you hear about us?______________

Legal Name:______________
Last First Middle

Mothers Name if Minor patient______________ Fathers Name if Minor Patient______________

Address ______________
Street Apt# City State Zip

Date of Birth______________ Sex ☐M ☐F Marital Status ☐Single ☐Married ☐Divorced ☐Widowed Other_______

Home Phone # ______________ Cell Phone# ______________ E-mail Address______________

Preferred Language: ______________ Do you have a Living Will or Medical Advance Directive (circle) Yes-No

Ethnicity (circle): Hispanic- Non-Hispanic- Unknown Race (circle): Black- White- Asian- Hispanic- Other:________

Employment Status: ☐Full-Time ☐Part-Time ☐Retired ☐Unemployed Other_________ ☐Student ☐Full-Time ☐Part-Time

Employer Name ______________Occupation______________

Employer Address______________Employer Phone______________

Spouse/Parent Name ______________ DOB__________Phone#______________
Last First

Emergency Contact Name______________Phone # ______________ Their Relationship to You______________

RESPONSIBLE PARTY INFORMATION (if other than parent/spouse)

Head of Household or Parent with Custody of Minor______________ Relationship to Parent______________

Mailing address______________ tel #______________

INSURANCE INFORMATION

POLICY HOLDER ***(If not patient)***

Name ______________
Last First Middle

Date of Birth__________ Relationship to patient______________

PRIMARY INSURANCE **EFFECTIVE DATE:**

Insurance Carrier ______________
Name Address Phone Number

Policy No.______________ Group No.______________

SECONDARY INSURANCE **EFFECTIVE DATE:**

Insurance Carrier ______________
Name Address Phone Number

Policy No. ______________ Group No. ______________

Authorization for Treatment

I authorize Z **MEDICAL CENTER INC** to perform procedures and treatment including administration of medicine and local anesthetics along with other surgical and medical procedures that may be medically necessary. I authorize the release of any medical information necessary (including the release of HIV/AIDS, Mental Health, Substance Abuse- to include alcohol and drugs and any reportable communicable diseases), to process a claim and hereby assign benefits payable to Z **MEDICAL CENTER INC** in the event of another health insurance becoming primary over my health insurance. To further provide continuity of care, I authorize the release of medical information to specialty physicians under contract with Z **MEDICAL CENTER INC**. Furthermore, any services not covered by my insurance will become my responsibility for full payment of services rendered by Z **MEDICAL CENTER INC**

____
Patient/Legal Guardian Signature

____
Patient/Legal Guardian PRINT

______________ Date

Z MEDICAL CENTER INC

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_______________________________________ **hereby authorizes the use or disclosure of the individually**
Print Patient/Legal Representative or Parent/Legal Guardian Name

Identifiable health information of _______________________________________ **as described herein.**
Print Patient Name Date of Birth

Person/organization authorized to **use/disclose** the information	If : Person/organization authorized to **receive** the information:
Name/organization Name/organization ____________	____________
Address ____________	Address ____________
City, State, Zip ____________	City, State, Zip ____________
Phone ____________ Fax ____________	Phone ____________ Fax ____________

For the purpose of: ☐ Legal Request ☐ Moving out of Area ☐ New Local Physician ☐ Other (please specify)

____

This authorization will expire on the following date, event or condition: ____________________ **If I fail to specify an expiration event or condition, I understand that this aut horization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization.** Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal and state law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/testing information in my record be released without my written authorization, except as otherwise required by law. I understand **that I may select the information from the list below to be released by placing my initials in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized re-disclosure of my health information.** I further understand that Z MEDICAL CENTER INC may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

Date(s) of Service: From: ____________________ **To:** ____________________

Place your INITIALS by each item to be released or reviewed:

____ Abstract of Record
____ Radiology only
____ Complete Record (charges may apply)
____ All diagnostic test results
____ Consultation/Progress Note(s)
____ Pathology/Operative Report(s)
____ Lab only
____ Other (specify) ____________

In addition, place your INITIALS by each specific item: (if applicable)

____ Mental Health
____ Drug and/or Alcohol
____ HIV Testing
____ AIDS Information
____ Genetic Counseling/Testing Information
____ STD/Communicable Diseases

_______________________________________ ____________________
Patient/Legal Representative or Parent/Legal Guardian ***Signature Required*** Date of Authorization

____________ ____________________ ____________________
Patient Date of Birth Social Security Number (Required) Identification Shown

_______________________________________ ____________________
Translator or Interpreter's Name Telephone Number

____
Address City State Zip Code

Official Use Only: _______________________________________
Name of Person Releasing Information **Date**

HIM 12.01.B.17

Z MEDICAL CENTER INC

I also authorize Z Medical Center Inc to obtain my prescription& medical history from other medial offices /pharmacies and other health organizations etc if needed______

(Initial here)

FINANCIAL AGREEMENT

In consideration of the patient receiving services from Z MEDICAL CENTER INC, I agree:

- I am responsible for all expenses for treating the patient.
- Payment of charges is due at the time of the appointment.
- If Physician Associates files my insurance for me, I agree to pay for non-covered insurance benefits, co-insurance, co-pays and deductibles.

Patient Signature

Responsible Party's Signature (Parent/Guardian of Minor)

Printed Name

Printed Name

Date

Date

AUTHORIZATION TO RELEASE INFORMATION & TO PAY BENEFITS

I authorize Z MEDICAL CENTER INC to release any of my medical information, including drug and alcohol and HIV positive test results, to my insurance company(s), as needed to process my insurance claim.

I authorize my insurance company to make payments directly to Z MEDICAL CENTER INC for covered medical and/or surgical services.

Patient Signature

Responsible Party's Signature (Parent/Guardian of Minor)

Printed Name

Printed Name

Date

Date

Z MEDICAL CENTER INC NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

"Z MEDICAL CENTER INC' Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting your physician's office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations.

We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I have read the Z MEDICAL CENTER INC Notice of Privacy Practices which is also available online on our site www.zclinic.org

Signature of Patient or Authorized Representative

____
Date Signed

Print Name

Print Name of Patient

____
Patient Date of Birth

Z MEDICAL CENTER USE ONLY

Patient declined signing this acknowledgment form

Reason given: ____

Staff Member Name: ____

Office Location: ______________________________ Date: ______________