Republic
Family Medicine llc
Yvonne Agius, M.D.
www.docagius.com
117 West State Highway 174 • Republic, Missouri 65738-1036 • Phone (417) 647-5131 • Fax (417) 647-5168

Patient Information

Last Name: ________________________ **First Name:** _____________________ **M.I.** ______

Date of Birth: ________________ **Sex:** ( ) M ( ) F **Weight:** ___________ **Height:** __________

Home Phone: ________________________ **Cell Phone:** __________________________

Address: _________________________ **City:** ______________ **State:** ___ **Zip:** _________

Email: ___________________________________ **SSN:** ___________________________

Marital Status: _____________________ **Referred by:** ___________________________

Pharmacy preference:

____

Other physicians involved in your care:

____

Reason for today's visit:

____

Allergies: (Medication/Food, indicate reaction) ( ) None

____

Medication List: (Please list name/dose/frequency if known)

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

Family History: (Please indicate deceased or alive, medical issues and age)

Children: ____

Father: ____

Mother: ____

Siblings: ____

Grandparents: ____

IN CASE OF EMERGENCY

Name of local friend or relative: _______________________________________

Relationship to patient: ___________________________________

Home Phone: _______________ **Cell Phone:** ______________ **Work Phone:** _______________

The above information is true to the best of my knowledge. I authorize Republic Family Medicine, LLC to act as my agent in helping obtain payment from my insurance company. I authorize my insurance benefits to be paid directly to Republic Family Medicine, LLC. I understand that I am financially responsible for any balance, and for any co-payments and/or yearly deductible as specified under my insurance contract. I also authorize Republic Family Medicine, LLC or my insurance company to release any information required to process my claims. I permit this form to be used as “Signature on File” for all my insurance submissions

Patient/Guardian Signature: ____________________________ **Date:** ____/____/______

Relationship of Guardian: ________________________

Republic
Family Medicine llc
Yvonne Agius, M.D.
www.docagius.com
117 West State Highway 174 • Republic, Missouri 65738-1036 • Phone (417) 647-5131 • Fax (417) 647-5168

Insurance Information
(If patient is not primary insured)

Patient's Name ______________________________________ **Birth date:** _____/_____/_______

Primary Insurance Subscriber: ____________________________ **SSN:** _____________________

Birth date: _____/_____/______ **Marital Status:** ___________________

Address : ______________________________ **City:** _____________ **State:** ____ **Zip:** ________

Home Phone: __________________________ **Cell Phone:** ________________________

Is this person a patient here? ( ) Y ( ) N Is this person covered by insurance? ( ) Y ( ) N

Occupation: ____________________________ **Employer:** _______________________________

Employer's Address: ________________________ **City:** _____________ **State:** ___ **Zip:** ______

Primary Insurance: ____

Policy Number: ____________________ **Group Number:** ___________________ **Copay:** _____

Subscriber's name: _______________________________ **Birth date:** ______/______/_________

Patient's relationship to subscriber: __________________________________

Secondary Insurance: (if applicable) ____

Policy Number: ____________________ **Group Number:** ___________________ **Copay:** _____

Subscriber's name: ________________________________ **Birth date:** ______/______/________

Patient's relationship to subscriber: __________________________________

Person responsible for bill (if different from primary subscriber):

Name: ___________________________ **Birth date:** _____/_____/________

Address (if different)**:** _________________________ **City:** _____________ **State:** ___ **Zip:** ______

Is this person a patient here? ( ) Y ( ) N Is this person covered by insurance? ( ) Y ( ) N

Occupation: ____________________________ **Employer:** _______________________________

Employer's Address: ________________________ **City:** _____________ **State:** ___ **Zip:** ______

Home Phone: __________________________ **Employer's Phone:** ________________________

The above information is true to the best of my knowledge.

Patient/Guardian Signature: _____________________________ **Date:** _____/_____/________

Relationship of Guardian: _________________________

Republic Family Medicine llc
Yvonne Agius, M.D.
www.docagius.com
117 West State Highway 174 • Republic, Missouri 65738-1036 • Phone (417) 647-5131 • Fax (417) 647-5168

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

I authorize disclosure of information regarding my condition, treatment, prognosis and billing to the following individual(s):

Name ___________________________________ Relationship _____________________

Name ___________________________________ Relationship _____________________

Name ___________________________________ Relationship _____________________

I also authorize all medical service sources and health care providers to use and/or disclose my protected health information ("PHI") described below to my agent identified in my durable power of attorney for healthcare named:

____

Authorization for release of PHI covering the period of health care (check a or b)

a. ( ) from (date) _____/___/_______ - to (date) _____/___/_______

b. ( ) all past, present and future periods.

I hereby authorize the release of PHI as follows: (check a or b)

a. ( ) my complete health record

b. ( ) my complete heath record *with the exception of the following information*:

( ) Mental health records

( ) Communicable diseases (including HIV and AIDS)

( ) Alcohol/drug abuse treatment

( ) Other (please specify): ____________________________

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until nine (9) months after my death or

_______________________, (date or event) at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient: ____ **Date:** ____/____/_________

Yvonne Agius, M.D.
www.docagius.com

117 West State Highway 174 • Republic, Missouri 65738-1036 • Phone (417) 647-5131 • Fax (417) 647-5168

HIPAA COMPLIANT AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ________________________________ Date of Birth: _____/_____/__________

Previous Name: __________________________ Social Security Number: ___________________

For the purpose of reviewing my records, I request and authorize:

Previous Provider/Clinic/Organization: ____

Phone: ___________________________ Fax: ______________________________

Address: _________________________ City: ________________ State: ____ Zip: ________

to release health care information of the patient named above to:

Republic Family Medicine, LLC
Yvonne Agius, M.D.
117 W. State Hwy. 174
Republic, MO 65738-1036
P: (417) 647-5131 F: (417) 647-5168

This request and authorization applies to:

( ) All Healthcare information

( ) Healthcare information relating to the following treatment, condition, or dates:

____

( ) Other: ____

1. I understand that my express consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.
2. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses. Any and all reports of any type or character.
3. I understand I have the right to revoke this authorization. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. To revoke this authorization I may contact Republic Family Medicine, LLC in writing.
4. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.
5. I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.
6. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment).
7. A copy or facsimile of this authorization shall be counted true and valid as original. This authorization will expire 180 days from the date signed.

Patient Signature: ________________________________ Date: ______/_____/_________

Guardian Signature (if minor): __________________________ Date: _____/_____/_______

Legal Relationship of Guardian: ____