Patient Information:

Last Name____________________ First Name ____________________ M.I.______

Address____________________ City____________ St______ Zip________

DOB____________ SS#____________ Sex: Male/Female **Marital Status:** Single/Married

Home# ____________ Cell#____________ Other#____________

Employer________________________ Phone#____________

Spouse or Parent Information:

Name________________________ Relationship____________

Address________________________ Phone#____________

Emergency Contact Information: (Other than above)

Name__________________ Phone#____________ Relationship____________

Insurance Information:

Primary Ins Co Name ____________________________

Name of Policy Holder________________________ **DOB**____________

Policy Holders Employer____________________________

Policy#____________________ **Group#**____________________

Names of other individuals covered by this Insurance:

1.____________________ **2.** ____________________
3.____________________ **4.** ____________________
5.____________________ **6.** ____________________

Secondary Ins Co Name ____________________________

Name of Policy Holder________________________ **DOB**____________

Policy Holders Employer____________________________

Policy#____________________ **Group#**____________________

Names of other individuals covered by this Insurance:

1.____________________ **2.** ____________________
3.____________________ **4.** ____________________
5.____________________ **6.** ____________________

Assignment of Benefits: I hereby grant permission to Family Medicine Associates to release any pertinent information to the above insurance company (s) upon request and any physicians to whom I might be referred. I also authorize payment directly to Family Medicine Associates for medical services rendered as described herein. I understand that I am financially responsible for those charges not paid by insurance.

Signature ________________________________ **Date** ____________

Family Medicine Associates

Permission to give Medical Record/Health Information

I, ______________________________, give permission to Family Medicine Associates to allow the person or persons listed below to obtain my medical records or health information.

1.____

2.____

(Please print names, phone number and relationship)

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Family Medicine Associates for the purpose of diagnosing or providing treatment to me, obtaining payment for healthcare bills or to conduct healthcare operations of Family Medicine Associates. I understand that diagnosis or treatment of me by Family Medicine Associates may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Family Medicine Associates is not required to agree to the restrictions that I may request. However, if Family Medicine Associates agrees to a restriction that I request, the restriction is binding on Family Medicine Associates and all of its physicians.

I have the right to revoke this consent, in writing, at any time, except to the extent that Family Medicine Associates or its physicians has taken action in reliance on this consent.

I understand I have a right to review Family Medicine Associates Notice of Privacy prior to signing this document. Family Medicine Associates Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health operations of Family Medicine Associates. The Notice of Privacy Practices for Family Medicine Associates is also posted in the waiting room. This Notice of Privacy Practices also describes my rights and the Family Medicine Associates duties with respect to my protected health information.

Family Medicine Associates reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy or by coming into the office and requesting one.

Signature____ Date________________________

(Patient or responsible personal representative)

Printed name ____________________________________Relationship if not patient______________