Print Form

ANDRES MEDICAL CLINIC

203 South Main Street, PO Box 1470, Anahuac, Texas, 77514 www.andresmedicalclinic.com

PATIENT INFORMATION

NAME_____DOB_____SSN#_____

MAILING ADDRESS_____

PHYSICAL ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE_____ WORK_____CELL_____

EMPLOYER_____

RESPONSIBLE PARTY/RELATIONSHIP_____

EMERGENCY CONTACT/PHONE NUMBER_____

PHARMACY USED FOR PRESCRIPTIONS { PHARMACY NAME/ ADDRESS/PHONE } _____

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INSURANCE INFORMATION

PLEASE HAVE THE MOST CURRENT INFORMATION AVAILABLE ON PRIMARY AND SECONDARY INSURANCE

A COPY OF YOUR DRIVER'S LICENSE IS REQUIRED

INSURANCE COMPANY NAME_____

CARD HOLDER_____ID#_____GROUP_____

INSURANCE COMPANY NAME_____

CARD HOLDER_____ID#_____GROUP_____

PAYMENT IS DUE WHEN SERVICE IS RENDERED

SELF-PAY PATIENTS I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED WITH ANDRES MEDICAL CLINIC IN RELATION TO ILLNESS AND ACCIDENTS. _____

AUTHORIZATION OF BENEFITS TO PROVIDER: I HEREBY ASSIGN AND RELINQUISH MY INTEREST IN AND TITLE TO MY INSURANCE BENEFITS TO ANDRES MEDICAL CLINIC FOR ALL MEDICAL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER THEY ARE COVERED BY MY INSURANCE OR NOT COVERED. _____

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE, ANDRES MEDICAL CLINIC TO FURNISH INFORMATION TO THE INSURANCE(S) CONCERNING MY ILLNESS/ACCIDENTS. I REALIZE THAT MY RECORDS MAY BE ELECTRONICALLY TRANSMITTED (FAXED) AND THROUGH SOME DEFAULT MAY NOT BE RECEIVED BY THE INTENDED RECIPIENT, SHOULD THIS OCCUR, I RELEASE ANDRES MEDICAL CLINIC FROM ALL LIABILITY.

F _____

PERMIT FOR DIAGNOSIS AND TREATMENT: I UNDERSTAND THAT PRESENTATION TO THE CLINIC IS INDICATED BY MY CONDITION OR MEDICAL NEED. I VOLUNTARILY AUTHORIZE AND CONSENT TO THE CUSTOMARY EXAMINATIONS, TEST AND PROCEDURES PERFORMED ON PATIENTS IN MY CONDITION AND TO ROUTINE MEDICAL TREATMENT ORDERED BY MY PHYSICIAN. _____

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

OUR NOTICE OF PRIVACY PRACTICES PROVIDES INFORMATION ABOUT HOW WE MAY USE AND DISCLOSURE PROTECTED HEALTH INFORMATION ABOUT YOU. YOU HAVE THE RIGHT TO REVIEW OUR NOTICE BEFORE SIGNING THIS CONSENT. 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 THE DIRECTOR OF COMPLIANCE PROGRAMMING, ANDRES MEDICAL CLINIC.

YOU HAVE THE RIGHT TO REQUEST THAT WE RESTRICT HOW PROTECTED HEALTH INFORMATION ABOUT YOU IS USED OR DISCLOSED FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS. WE ARE NOT REQUESTED 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 OR HEALTHCARE OPERATIONS. YOU HAVE THE RIGHT TO REVOKE THIS CONSENT, IN WRITING EXCEPT WHERE WE HAVE ALREADY DISCLOSURES IN RELIANCE ON YOUR PRIOR CONSENT.

NAME_____ **HOME PHONE**_____

ADDRESS_____ **EMAIL**_____

HAVING HAD THIS OPPORTUNITY TO READ AND CONSIDER THE CONTENTS OF THIS CONSENT FORM AND YOUR NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT BY SIGNING THIS CONSENT I AM GIVING MY CONSENT TO YOUR USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES AND HEALTHCARE OPERATIONS.

PATIENT SIGNATURE_____ **DATE SIGNED**_____

IF THIS CONSENT IS SIGNED BY A PERSONAL REPRESENTATIVE ON BEHALF OF THE PATIENT.

PRINTED NAME OF REPRESENTATIVE_____

REPRESENTATIVE SIGNATURE_____

DATE SIGNED_____