Patient Information

Name | Social Security Number

Address

City | State | Zipcode

Home Phone | Cell Phone | Reffered By

Sex | Age | Birth Date | Single Married Widowed

Occupation | Employed By

Primary Insurance Carrier

X Insurance Company Name | Phone

Address

Identification Number | Group Number

Subscriber's number If different than Yourself

Subscriber Sex | Age | Subscriber Birth Date | SS#

Employed By | Work Phone

Secondary Insurance Carrier

X Insurance Company Name | Phone

Address

Identification Number | Group Number

Subscriber's number If different than Yourself

Subscriber Sex | Age | Subscriber Birth Date | SS#

Employed By | Work Phone

INSURANCE AUTHORIZATION AND ASSIGNMENT

i hereby authorize payment directly to US Primary & Urgent Care, all insurance benefits otherwise me for the services rendered I understand that i am financially responsible for all charges, I authorize the above doctor and/or provider or supplier of services in this office to release info required to secure the payment of benefits I authorize the use of this signature on all insurance submissions.

I also understand that a $25.00 fee will be charged for missed appointment not cancelled 24 hours, the scheduled appointment time.

X Signature | Date | Acct#

HIPAA

Health Insurance Portability and Accountability Act (HIPAA) Consent.

I Consent the use or disclosure of my health information (PHI) by Medical Office, for the purpose of Treatment, Payment, and Health Care Operations. I have received a copy of the Notice of Privacy Practices and understand I have a right to preview prior to signing this document.

I UNDERSTAND:

1. Service to me may be conditioned upon my consent as evidenced by my signature on this document.
2. I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment, or health care operations of the practice. Medical Office is not required to agree to the restrictions that I may request. However, if Medical Offices agrees to a restriction that I request, the restriction is binding on Medical Offices.

3. I have the right to revoke this consent in writing, at any time, except to the extent that Medical Office has taken action in reliance on this consent.

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

THE NOTICE OF PRIVACY PRACTICES DESCRIBES :

1. The type of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or the performance of health care operations performed by Medical Offices.
2. My rights and the duties of Medical Offices with respect to me PHI.

Full Name (Please Print) _____

Address _____

City, State, Zip _____

Signature of Patient or Guardian _____ Date _____