EAST MEMPHIS
URGENT MEDICAL CLINIC

Patient Information

_____ _____

Name (First, M.I., Last) **Chief Complaint / Reason for Visit**

_____

Address

_____

City **State** **Zip**

_____-_____-_____ _____ _____-____-_____ **Male / Female**

Date of Birth **Age** **SS Number** **Sex**

_____ _____ _____ **S, M, D, W**

Cell Phone **Home Phone** **Work Phone** **Marital Status**

_____

Email Address

Race (Circle Below)

American Indian, Asian, African American (Black), Caucasian (White)

Other _____

Ethnicity (Circle One)

Hispanic or Latino, Not Hispanic or Latino, Other Preferred Language_____

Emergency Contact: _____ Phone:_____

Insurance

PRIMARY INSURANCE CARRIER

_____

Insurance Company Name

Patient's relationship to Insured

Self Spouse Child

SECONDARY INSURANCE CARRIER

_____

Insurance Company Name

Patient's relationship to Insured

Self Spouse Child

RESPONIBLE PARTY IF MINOR

_____ _____ _____

Insured Name Date of Birth SS Number

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and / or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and other agency reimbursements to this center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: _____ Date: _____

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Patient Name_____ DOB_____

I understand that under HIPAA, I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to

- Conduct, plan, and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations, such as quality assessments and provider certifications.

I have been informed by you or your Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practice from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practice.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry our treatment or obtain payment of health care operations. I also understand you are not required to agree to my requested restriction, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent you have taken action relying on this consent.

PATIENT AUTHORIZATIONS

Please write the name of the person to whom you wish us to disclose your health information:

____Spouse:_____

____Parents:_____

____Children:_____

____Other:_____

____**DO NOT RELEASE ANY MEDICAL INFORMATION TO ANYONE**

Relationship to Patient (if minor):_____

Signature:_____ Date:_____