Eastern Shore Family Practice
INFIRMARY HEALTH

Patient Name: _____ Patient Birthdate: _____/_____/_____
(*last*) (*first*) (*middle initial*)

Patient Sex: Male Female Patient Social Security #: _____/_____/_____ Marital Status: _____

Ethnicity (circle) American Indian Black Caucasian Hispanic Non Hispanic Other

Race: (circle) American Indian Asian Black or African American Caucasian/White Hispanic Non Hispanic Other

Mailing Address: _____

City: _____ State: _____ Zip: _____ E-mail: _____

Home Phone: (_____)_____-_____ Cell: (_____)_____-_____ Work Phone: (_____)_____-_____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Student ☐ Retired

Employer: _____

Emergency Contacts

Name: _____ Relationship: _____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

Primary Insurance Information ***Please present all insurance cards to the Front Desk***

Insurance Company: _____

Name of Policy Holder/Insured: _____ Insured Date of Birth: _____/_____/_____

Relationship to Patient:_____ Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed

Seconday Insurance *(if applicable)*

Insurance Company: _____

Name of Policy Holder/Insured: _____ Insured Date of Birth: _____/_____/_____

Relationship to Patient: _____ Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed

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Person responsible for any balance on this account - (only if the patient is a minor)

Name: _____ Social Security #: _____/_____/_____

Relationship: _____ Birthdate: _____/_____/_____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

Employer: _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed

Eastern Shore Family Practice
INFIRMARY HEALTH

27961 US Hwy. 98, Suite 14
Daphne, AL. 36526
251-626-1175 | Fax 251-625-1507

For use and disclosure of Protected Health Information (PHI)
Authorization Form - Release of Information(ROI)

Patient Name: _____ Date of Birth: _____

By signing this Authorization Form, I understand I am giving authorization to IMC-Eastern Shore Family Practice +medical record custodian, to release my protected health information including Medical, Psychiatric, Alcohol, HIV, Drug Abuse and/or Financial Information contained in my records. I authorize IMC-Eastern Shore Family Practice to:

[ ] Disclose (release) to: or [ ] Obtain (request) from:

Name of Person or Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Purpose of release: ☐ Continuity of Care ☐ Change of PCP ☐ Insurance Claim
☐ Personal Use ☐ Legal Use
☐ Other _____

Personal Health Information to be disclosed/or obtained:

___ All Medical Records
___ Lab Reports
___ Operative Notes ___ Progress Notes
___ Pathology Reports ___ Radiology Reports
___ Immunization Records ___ Other _____
Comments: _____

I understand that I can revoke this authorization at any time except to the extent that any action has been taken in reliance on this authorization. I can revoke this authorization by submitting a written request to IMC-Eastern Shore Family Practice.

This authorization will expire 1 year from the date of signing below unless specified otherwise. Date of expiration if different: _____

I understand that I am not required to sign this form in order to receive treatment from IMC-Eastern Shore Family Practice.

_____ _____
Signature of Patient Date

_____ _____ _____
Signature of Authorized Representative Date Relationship

☐ Records given to patient/representative Date: _____ Signature: _____

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Acknowledgement of Receipt of Privacy Practices (HIPAA)

You acknowledge that you were offered a copy of our Notice of Privacy Practices. If you would like to receive a paper copy at any time in the future, you can call (251) 626-1175.

_____ _____/_____/_____
Patient Name (please print) Date

_____
Signature

If the patient is unable to sign, please indicate the reason why:

_____ Admitted directly to treatment area
_____ Left AMA or without being seen
_____ Unresponsive
_____ Not competent (POA signed)
_____ Refused to sign
_____ Patient is a minor (Guardian signed)

Please list anyone with whom we can speak with about your account:

	Name	Relationship	Medical?	Billing?
1.	_____	_____	□Y □N	□Y □N
2.	_____	_____	□Y □N	□Y □N
3.	_____	_____	□Y □N	□Y □N
4.	_____	_____	□Y □N	□Y □N

☐ I <u>do not</u> wish to have my health care discussed with anyone.

FOR OFFICE USE ONLY

_____ _____/_____/_____
Facility Representative Date

Eastern Shore Family Practice
INFIRMARY HEALTH

IMC-Patient Responsibility Consent Form

_____ _____ _____/_____/_____

Patient Last Name | Patient First Name | Date of Birth

Assignment of Benefits

I request that payment of authorized Medicare and/or Medicaid benefits to be made on my behalf for services in or by the Clinic, shall be made to the Clinic, and I specifically assign such benefits to the Clinic. If applicable, I hereby assign and authorize payment directly to the Clinic of all medical benefits under any insurance or third party plan payable to me or which I am otherwise entitled.

Release of Information

I authorize any holder of medical information about me to release to Medicare, Medicaid, and/or other health insurance or third party plan and their respective agents any information needed to determine these benefits or related services.

Financial Responsibility

I understand that I am responsible for all charges not paid by my insurance plan except those amounts that the Clinic is contractually obligated to write off. I understand that I am responsible for all non-covered services and by signing this form I acknowledge I have been made aware of my obligation prior to receiving such services. I understand that if I do not pay for the charges for which I am responsible, the Clinic may turn my account over to a collection agency. I understand that should my account be turned over to a collection agency I may be charged a collection fee, not to exceed 25% of my account, and I accept these fees charged by the Clinic as a legal and lawful debt and agree to pay such fee if charged.

Telephone and Alternative Communication Consent

I understand the Clinic or its agents may use pre-recorded/artificial voice messages and or/auto-dialing devices to remind me about appointments or notify me of other information and I expressly consent to the Clinic or its agents use of any number associated with my account including any wireless number. I also authorize the Clinic or its agents to contact me at any number associated with my account, including wireless numbers, including contact by means of pre-recorded or artificial voice messages and/or automatic dialing devices, for the purposes of collecting on my account. I also authorize the Clinic to communicate with me using any email address I provide to the Clinic.

No Show Appointments

I understand when I make an appointment, time is reserved for me that cannot be scheduled for someone else. Recognizing this I will, exempting unforeseen emergencies, notify the Clinic no later than the business day before my appointment should I not be able to keep my appointment. If I do not, I understand the Clinic has the right to charge me a no-show fee and I acknowledge such a charge would be a legal and lawful debt and agree to pay such fee if charged.

Minors

I understand that I am responsible for this child's account and any agreement otherwise by means of a court decree or other valid agreement is between me and another party.

Authorization to Treat

I voluntarily consent to medical treatment and diagnostic procedures provided by the clinic. I am aware that the practice of medicine & surgery is not an exact science. I acknowledge that no guarantees have been made as to the results of treatments and/or examinations.

_____ _____/_____/_____

Patient (or Responsible Party) Signature | Date