Consent for Treatment

I authorize and consent to the rendering of medical care, including diagnostic procedures and medical treatment by authorized members of East Springdale as many in their professional judgment be necessary for the below named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment.

Assignment of Insurance Benefits

Patient-Physician Agreement: I, the undersigned, authorize East Springdale to release any information acquired in the course of my examination or treatment to my insurance company(s) or another physician. I, recognizing that the medical insurance I possess may not completely cover the fee(s) for professional services rendered me; hereby agree that I am responsible for said fee(s). I authorize payment directly to me for their services. A photocopy hereof shall be valid as the original. I am aware that I may inquire of my physician the fee(s) for any professional services required and/or rendered.

Authorization to Release Information

I authorize East Springdale to release any information requested by the insurance company necessary to collect benefits under any policy we make claim against for services on this or a related date of service.

Guarantee of Payment

I understand that office visits are to be paid for at the time of service unless other arrangements have been made. I understand that I am responsible for the balance not covered by insurance. I understand that East Springdale does not accept any insurance policy assignment as a guarantee of full payment.

Patient Signature:
X__________________________________________
________________________________________________
(Patient or Parent/Guardian if under 18 years of age)
________________________________________________
Relationship of Guardian
__________________________________________
Date
PATIENT INFORMATION - PLEASE PRINT

SOC SEC #: __________________-__________-__________

Name: ____________________________________________

Last       First       Mid Initial

Address: __________________________________________ 

City: _______________________ State: _______ Zip: __________

State: __________________ Zip Code: _______________

SEX: [ ] Male   [ ] Female

Date of Birth: _____-____-______ Age: _____yrs

Home Phone: ____________________________

Work Phone: _________________________ Ext: ______

Cell Phone: ____________________________

Employer: ____________________________

Work Address: _______________________________

City: _______________ State: ___ Zip: ______

Occupation: ____________________________

Email: ______________________@___________

MARITAL STATUS: [ ] Married   [ ] Single   [ ] Divorced

[ ] Partner   [ ] Widowed   [ ] Separated

Referral

Who referred you to our clinic? (PLEASE CHECK BOX)

[ ] Washington Regional Medical Center  [ ] Community or Company Health Fair

[ ] Newspaper or Magazine  [ ] Treated by Physician in hospital

[ ] Recommended by friend or family member  [ ] Internet

[ ] Drove by Location of Clinic  [ ] Phone Directory (Yellow pages)

[ ] Employed

[ ] Insurance Plan Directory

[ ] New Patient

[ ] Internet

[ ] Treated by Physician in hospital

[ ] Other: ____________________________

SPOUSE/PARENT INFORMATION

Spouse/Parent Name: _________________________________

Cell: _______________________________________

Employer: _______________________________________

Work: ___________________ Ext: _____________

Work Address: ___________________________________

City: _______________ State: ________ Zip: __________

Occupation: _______________________________________

Social Sec. #: __________-_______-___________

Spouse/Parent SEX: [ ] Male   [ ] Female

Spouse/Parent Date of Birth: _____/_____/_____

Emergency CONTACT INFORMATION

Emergency contact: ________________________________

Cell Phone: ____________________________

Address: _______________________________________

City: _____________________ State: _______ Zip: __________

Home Phone: ____________________________

Relationship to Patient: ______________________
PRIMARY INSURANCE

Patient’s Relationship to **Main Policy Holder**: ☐ Myself  ☐ Spouse  ☐ Child  ☐ OTHER: ______________________

Name of Insurance Company: ________________________________________________________________

Insurance Company Address: ________________________________________________________________

City: __________________________________________ State: ____________________________ Zip: ___________________

ID# ___________________________________________ Group # _________________________________________________

Insurance Company’s Phone Number: __________________________________________________________

Main Holder’s Name: __________________________________  Main Holder’s Date of Birth: _____/_____/______

Main Holder’s Address: ________________________________   Main Holder’s Soc Sec#: _______-______-______

City: ________________________________________________ State: _____________________ Zip: ____________________

SECONDARY INSURANCE

Patient’s Relationship to **Main Policy Holder**: ☐ Myself  ☐ Spouse  ☐ Child  ☐ OTHER: ______________________

Name of Insurance Company: ________________________________________________________________

Insurance Company Address: ________________________________________________________________

City: __________________________________________ State: ____________________________ Zip: ___________________

ID# ___________________________________________ Group # _________________________________________________

Insurance Company’s Phone Number: __________________________________________________________

Main Holder’s Name: __________________________________  Main Holder’s Date of Birth: _____/_____/______

Main Holder’s Address: ________________________________   Main Holder’s Soc Sec#: _______-______-______

City: ________________________________________________ State: _____________________ Zip: ____________________
GENERAL INFORMATION
Who is responsible for Payment?: □ Myself  □ Other: ____________________________ (FILL OUT BELOW)

Responsible Party Name: ______________________________  Responsible Party DOB: ______/_____/_____
Relationship to Patient:  □ Self  □ Spouse  □ Child  □ OTHER SS#___________-_________-___________
Address: __________________________________________  Phone#: _______________________________

Have you ever been seen as patient at one of our Washington Regional Medical System Clinics?  □ Yes  □ No
If Yes, When?:_________/__________/________ Where?: ______________________________________________

RELEASE OF INFORMATION (spouse, children, parents, etc)
Who may we discuss your information with? For example: Medical issues/care, results, billing, etc.
Name: __________________________________________  Relation to Patient: ____________________________
Name: __________________________________________  Relation to Patient: ____________________________
Name: __________________________________________  Relation to Patient: ____________________________

Preferred Language:  □ English  □ Spanish  □ Marshallese  □ Arabic  □ DECLINE  OTHER: __________________

Race:  □ White  □ African American  □ Asian  □ Native Hawaiian/Other Pacific Islander
      □ Native American Indian/Alaskan  □ Hispanic  □ Unknown  □ DECLINE

Ethnicity (Origin):  □ Not Hispanic or Latino  □ Hispanic or Latino  □ Unknown  □ DECLINE

Preferred Communication Method: □ Print  □ Save to Flash Drive  □ DECLINE

Wellness Reminders: □ Mail  □ Cell Phone  □ Home phone  □ Work Phone  □ DECLINE

PREFERRED PHARMACY: __________________________  LOCATION: __________________________

I authorize release of any medical information necessary to process my claim to all my insurance companies. I authorize direct payment of medical benefits to the provider. I permit a copy of this authorization to be used in the place of the original. I consent for my photo to be taken. I understand that I am responsible for any amount not covered by insurance. I permit the faxing and electronic transmission of medical information to other health care providers, attorneys, or insurance companies involved in my care. I give my permission for messages to be left on my answering machine or sent by email. I, the undersigned, authorize and consent to the rendering of medical care, including diagnostic procedures, and medical treatment by authorized members of Washington Regional Medical System or their designees, as may in their professional judgment be necessary for the above named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. I have received a copy of the Notice of Privacy Practices of the clinic. I permit this facility to obtain my medication history electronically.

X_________________________________________  Date: _________/__________/________
Signature (Patient or Parent/Guardian if minor)