NEW PATIENT INFORMATION

Patient's Full Name_____ **Date of Birth:** _____ **Age:** ____

SSN_____-_____-_____Sex: **male** **female** Marital Status: S M W D Separated

Email address: _____

Race: (Please circle all that apply) American Indian/Alaskan Native Hispanic/Latino Asian Black/African American Native Hawaiian/other Pacific Islander White Other_____ Would rather not say

Home Address: _____

City: _____ ST: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Employer: _____ Supervisor: _____

Employer's Address: _____

Primary Care Doctor's Name: _____ Phone: _____

Patient's Spouse_____ Phone: _____

Emergency Contact: _____ **Phone:** _____ Relationship _____

Who is responsible for payment, if not patient?

Name: _____ Phone: _____

Billing Address: _____ City, ST & Zip_____

Relationship to Patient: _____ Employer: _____

Primary Insurance: _____ ID#: _____

Subscriber Name: _____SSN: _____ DOB: _____

Secondary Insurance: _____ ID# _____

Subscriber Name: _____SSN: _____ DOB: _____

I hereby authorize Verona Family Medicine and Urgent Care Clinic to release any information concerning my illness/accident and treatment to Insurance Carriers. I hereby assign East Main Family Medical Clinic, LLC payments for medical services rendered to myself or my dependents. I understand that I am financially responsible for all charges whether or not covered by insurance. I will be responsible for any returned check fees.

_____ _____

Signature of Patient or Guardian Date

How did you hear about us? Newspaper Radio TV Magazine Billboard

If a friend referred you, who was it? _____

VERONA FAMILY MEDICINE AND URGENT CARE CLINIC
5024 RAYMOND AVE
VERONA, MS 38879

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____City: _____ State: _____ Zip: _____

Social Security Number: _____ Home #_____ Cell#_____

Emergency Contact: _____Phone# _____Relationship _____

I authorize _____ to disclosure the information from my records to the Verona Family Medicine and Urgent Care Clinic, Inc.

I authorize the Verona Family Medicine and Urgent Care Clinic, Inc. to disclose the information from my records to: _____

I authorize the disclosure of:

- o Verbal/Written Treatment Progress Notes
- o Medications
- o Disability
- o Progress Notes
- o Lab Results
- o X-Rays
- o Psychiatric/Psychological Evaluations

The Purpose of the disclosure:

- o Continuity of Care
- o Determine Eligibility for
- o For Health/Life Insurance
- o Legal
- o My Personal Records
- o Other

I understand that the information in my health record may include information relating to sexually transmitted disease; acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been used or disclosed under this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If this authorization has not been revoked, it will terminate on the following date in the event or condition: _____. If I fail to specify an expiration date, even or condition, this authorization will automatically expire in six (6) months.

I understand that I can refuse to sign the authorization, I need not sign this form to obtain treatment, payment, or health pan enrollment or eligibility. I understand that any disclosure of information carries with it the potential for redisclosure by the recipient and that the information may then be no longer protected by federal confidentiality rules.

_____

Signature of Patient or Representative Print Name of Patient Representative

_____

Date Relationship to Patient

VERONA FAMILY MEDICINE AND URGEN CARE
5024 RAYMOND AVE
VERONA, MS 38879

PATIENT CONSENT FOR TREATMENT ASSIGNMENT
OF INSURANCE BENEFITS AUTHORIZATION TO
RELEASE INFORMATION

CONSENT FOR MEDICAL TREATMENT

(This is good for my lifetime)

My permission is given today for any medical treatment, including but not limited to, examination injections, diagnostic testing, medical procedures, as may be deemed advisable by members of the staff at East Main Family Medical Clinic.

AUTHORIZATION TO RELEASE INFORMATION

(This is good for my lifetime)

I authorize East Main Family Medical Clinic to release any medical information necessary to process this claim (Medicaid, Medicare, Insurance). I authorize any holder of medical or the fiscal agent for the Medicare or Medicaid, any information needed to determine these benefits or the benefits payable for related serviced.

ASSIGNMENT OF BENEFITS

(This is good for my lifetime)

I request and authorize payment of medical benefits to the East Main Family Medical Clinic for services provided. I request that payment of authorized Medicare and Medicaid (for any other insurance company that will pay benefits on my behalf) benefits be made on my behalf to Verona Family Medicine and Urgent Care Clinic.

NOTICE OF PRIVACY PRACTICES

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature of Patient or Patient Representative: _____

Relationship: _____

Patient is unable to sign because: _____

VERONA FAMILY MEDICINE AND URGEN CARE
5024 RAYMOND AVE
VERONA, MS 38879
662-432-0782

PATIENT CONSENT FOR TREATMENT ASSIGNMENT OF INSURANCE BENEFITS AUTHORIZATION TO RELEASE INFORMATION

CONSENT FOR MEDICAL TREATMENT
(This is good for my lifetime)

My permission is given today for any medical treatment, including but not limited to, examination injections, diagnostic testing, medical procedures, as may be deemed advisable by members of the staff at Verona Family Medicine and Urgent Care

AUTHORIZATION TO RELEASE INFORMATION
(This is good for my lifetime)

I authorize Verona Family Medicine and Urgent Care to release any medical information necessary to process this claim (Medicaid, Medicare, Insurance). I authorize any holder of medical or the fiscal agent for the Medicare or Medicaid, any information needed to determine these benefits or the benefits payable for related serviced.

ASSIGNMENT OF BENEFITS
(This is good for my lifetime)

I request and authorize payment of medical benefits to the Verona Family Medicine and Urgent Care for services provided. I request that payment of authorized Medicare and Medicaid (for any other insurance company that will pay benefits on my behalf) benefits be made on my behalf to Verona Family Medicine and Urgent Care Clinic.

NOTICE OF PRIVACY PRACTICES

I HAVE RECEIVED the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature of Patient or Patient Representative: _____

Relationship: _____

Patient is unable to sign because: _____

MEDICAL HISTORY

	Name of Operation	Date	Doctor	Reason	Hospital
1					
2					
3					
4					
5					

Past Surgical History

Have you or a family member had problems with anesthesia? ___NO ___YES Explain: _____
Have you or a family member had problems with bleeding? ___NO ___YES Explain: _____
Do you have a sensitivity or allergy to Latex? ___NO ___YES Explain: _____

Past Medical Illness (check all that apply)

____NONE ____ Diabetes ____ Heart Attack (Date: _____) ____ Lung Disease
____ Angina Stroke (Date: _____) ____ Congestive Heart Failure ____Heart Disease
____ Gastric Reflux ____ Ulcers ____ Thyroid (Treatment _____) ____ Arthritis
____ Hepatitis/jaundice (Date: _____) ____ High Cholesterol/lipids ____ Asthma
____ Depression ____ Kidney Disease ____ Cancer: (Date, type & treatment: _____)
____ Anxiety ____ Blood transfusion/reaction (Date: _____)
____ Others: _____

Drug Allergies _____ **None Known**

	Name of Medication	What happens when you take this drug?
1		
2		
3		

What Medication are you taking now? _____ **None**

	Name of Medication	Strength (? Mg)	Reason	How many times a day?
1				
2				
3				
4				
5				
6				
7				
8				

Social History

1. Are you: ___ Married ____ Single ____ Divorced ____ Widowed
2. How many children do you have? ____ Are you currently pregnant? YES NO Due Date: _____
3. Current Occupation _____ How long? _____ Noise exposure: Mild, Moderate, Severe
4. Do/did you smoke or chew tobacco? YES NO How much? _____
5. When did you quit smoking or chewing tobacco? _____
6. How much alcohol do you drink per week? _____ What type? _____

VERONA FAMILY MEDICINE AND URGENT CARE CLINIC

PATIENT FINANCIAL RESPONSIBILITY & AUTHORIZATION FORM

Thank you for choosing **Acute Care Family Medical Clinic** for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- ® The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- ® We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- ® Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatments not covered by their insurance plan.
- ® Copays are due at time of service.
- ® Self—pay patients must pay basic visit fee of $60.00 prior to being seen. Fees accumulated for lab test, x-rays, shots&/or other services provided during the visit will be due at the time of checkout.
- ® Coinsurance, deductibles and non-covered items are due 30 days from the receipt of billing.
- ® Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include, but are not limited to:

    - ® Charge for returned check-**$40.00**

By my signature below, I hereby authorize assignment of financial benefits directly to **Acute Care Family Medical Clinic** and any associated healthcare entities for services rendered as allowable understand third party contracts. I understand that I am financially responsible for charges not covered by this agreement.

Patient Acknowledgement and Authorization

We respect patient confidentiality and only release personal health information about you in accordance with the State and Federal law. The attached notice describes our policies related to the use of records of your care and how you may get access to this information. Please review this policy carefully.

By my signature below, I acknowledge that I have received and read the privacy notice provided by **Acute Care Family Medical Clinic.** I hereby authorize **Acute Care Family Medical Clinic** and the physicians, staff, and hospitals associated with **Acute Care Family Medical Clinic** to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.

Patient Name _____ Date of Birth _____

Patient/Guardian Signature _____ Date _____

Verona

Family Medicine

& Urgent Care

I approve of Verona Family Medicine & Urgent Care to send me a reminder of my next appointment by use of text message, voice message, or email to the phone number(s) and/or email address below:

Telephone Number (s): _____

Email Address: _____

Signature: _____

Date: _____