CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

NAME: ______________________________ DATE OF BIRTH: ______________

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communicating among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations- and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Guarantee of Payment

I understand that it may become necessary to release my protected health information to financial parties, credit card entities, banks and financing companies, when requested, to facilitate your payment in matters of financial dispute. Any scheduled procedure cancelled by me with less than 48 hours notice will result in forfeiting any money paid.

SIGNATURE ________________________________ DATE ______________

Patient Registration and History

Patient: ____
Last Name First Name Middle

Preferred Contact #: (please indicate home, work or cell) ______________________

Phone #2: ______________________ **Phone #3:** ______________________

Email address: ______________________

Local Address: ____

City: ______________________ **State:** __________ **Zip:** ______________

Billing/Permanent Address: ____

City: ______________________ **State:** __________ **Zip:** ______________

Emergency contact: ______________________ Phone: ______________ Relationship: ______________

Social Security #: ______________ **Sex:** Male Female **Birthdate:** __________ Age:___

Married____ Single____ Widowed ____ Separated_____ Divorced_____ Height:______ Weight:_________

Occupation: ______________________ **Employer:** ______________________

Referred by: ______________________

History of MRSA: Yes _____ No _____ Primary Physician: ______________________

Reason for Visit: ____

Allergies to medicine: No_____ Yes______ Please list: ______________________

Current Medications/Vitamins: ____

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Are you a smoker? (circle) Yes / No Ex-Smoker? Yes / No

How much are (were) you smoking? ______________ How long ? ______________ Quit how long ago? ______________

How much alcohol do you drink? (circle) <1 drink/day 1 - 2 drinks/day >2 drinks/day

Please circle all of the following medical conditions you now have or have had in the past: high blood pressure / bleeding tendency / problems scarring or delayed healing / cancer / hepatitis / HIV / diabetes / blood transfusions / glaucoma / dry eyes / lung disease / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / heart attack / stroke / epilepsy / heart burn / intestinal ulcers or bleeding / thyroid disease / depression / mental illness / drug or alcohol addiction / other ______________________

Is there any possibility that you might be pregnant at this time? Yes / No

List all surgeries that you have had (include plastic surgery) ______________________________

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I agree that the above information is accurate to the best of my ability.

Signature: ______________________

Patient #:_________ Date: ______________________