TDC
THE DOCTORS CLINIC

PATIENT INFORMATION

Patient	Responsible Party
Name	Name
Mailing Address	Mailing address
Patient Primary Contact Phone Number:	Primary Contact Phone Number:
Employer	Employer
SSN DOB Gender	SSN DOB Gender
Primary Ins	Subscriber Name
Group/Pol	Relationship
Secondary Ins	Subscriber Name
Group/Pol	Relationship

Race: ☐ Asian ☐ Black/African American ☐ Caucasian ☐ Hispanic ☐ Native American/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Unknown/Refused ☐ Multi-Racial

Ethnicity: ☐ Latino/Hispanic ☐ Non-Latino/Non-Hispanic ☐ Unknown/Refused

WHO MAY WE CONTACT IN CASE OF EMERGENCY

Name	Relationship	Primary Phone Number	Secondary Phone Number

I request information about a LIVING WILL Yes No **(Please Circle)**

ASSIGNMENT OF INSURANCE BENEFITS AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize direct payment of surgical/medical benefits to The Doctors Clinic for services rendered. I understand that I am financially responsible for any balance not covered by my insurance and for payment regardless of insurance pending. I hereby authorize The Doctors Clinic to release any medical or incidental information that may be necessary for either medical care or in processing application for financial benefit.

Signature _____Date _____Relationship(if other than patient)_____

Please Read Carefully and Sign

I am **not** receiving DSHS Medical Assistance and I agree to pay for the services. If I later become eligible for DSHS Medical Assistance, I agree to notify the provider's billing office.

Signature_____ Date _____

I verify that the information contained on this form is accurate.

Signature_____ Date _____

RELEASE

_____ I would like The Doctors Clinic to leave me messages of a non-sensitive nature that may contain protected health care information on my voice mail, answering machine or with a family member, **OR**

_____ I would like The Doctors Clinic to leave me messages of a non-sensitive nature that may contain protected health care information on my voice mail, answering machine or with a family member **only at the following designated telephone number: _____, OR**

_____ I do not wish to have The Doctors Clinic leave me messages containing protected health care information.

Signature _____Date _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorized or compels us to do so. You may see your record or get more information about it by contacting your provider's office.

Our **Notice of Privacy Practices** describes in greater detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____ _____
Patient or legally authorized individual signature Relationship DATE

MEDICARE BENEFICIARY LIFETIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished by or in The Doctors Clinic including physician services. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits for related services.

Signature_____ Date_____ Medicare #_____

MEDIGAP AUTHORIZATION FOR AUTOMATIC CROSSOVER COMPANIES AUTHORIZED BY MEDICARE CENTERS FOR MEDICARE & MEDICAID SERVICES

This authorization covers the Medigap insurances that are signed up with and approved by Medicare for automatic crossover for participating doctors. The Doctors Clinic is NOT submitting claims to the secondary plans. It is an arrangement between your insurance company and Medicare. Check with your insurance plan if you have questions.

I request that payment of authorized Medigap benefits be made either to me or on my behalf for any services furnished by or in The Doctors Clinic including physician services. I authorize any holder of medical or other information about me to release to my Medigap insurance carrier and its agents any information needed to determine these benefits or the benefits for related services.

Signature _____ Date _____ Insurance Co. _____

CREDIT POLICY

All Charges are due and payable within 30 days following the date they are incurred, unless you arrange an extended payment plan with our credit department. A finance charge of 1% a month (annual percentage rate of 12%) will be added to all accounts over 35 days. There will be a minimum charge of $0.50. The finance charge will be waived if special arrangements are made with our Credit Department. Any check returned for NSF may be charged a handling fee.

This form will be retained in your medical record.

Date: «CurrentDate»