Patient Information Form

Patient	Responsible Party
Name	Name
Mailing Address	Mailing address
Phone Number: **Hm:** **Cell:**	Phone Number: **Hm:** **Cell:**
Employer Work Phone	Employer Work Phone
DOB Gender SSN	DOB Gender SSN
Primary Ins	Subscriber Name
Group/Policy #	Relationship to Patient
Secondary Ins	Subscriber Name
Group/Policy #	Relationship to Patient
Marital Status:☐ Single ☐ Married ☐ Widow	Marital Status: ☐ Single ☐ Married
Race: ☐ Asian ☐ Black/African American ☐ Caucasian ☐ Hispanic ☐ Native American/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Multi-Racial ☐ Unknown/Refused	
Ethnicity: ☐ Latino/Hispanic ☐ Non-Latino/Non-Hispanic ☐ Unknown/Refused	
Preferred Language: ☐ English ☐ Arabic ☐ Armenian ☐ Chinese ☐ French ☐ German ☐ Greek ☐ Gujarati ☐ Hindi ☐ Italian ☐ Japanese ☐ Korean ☐ Persian ☐ Polish ☐ Portuguese ☐ Russian ☐ Spanish ☐ Tagalog ☐ Urdu ☐ Vietnamese ☐ Other _____	

Who May We Contact in Case of Emergency

Name	Patient Relationship to Contact?	Primary Phone Number	Secondary Phone Number

LIVING Will

I request information about a Living Will: ☐ Yes ☐ No

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** _____

The above information contained in this form is true and accurate to the best of my knowledge. I understand I am responsible for charges associated with medical services and agree to pay all bills within 30 days from the receipt of statement, unless other arrangements are made. I authorize the physician and clinic to release any information to process insurance claims. I also authorize my insurance to be paid directly to the clinic.

Signature _____ 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 Franciscan Medical Group, 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_____

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. Franciscan Medical Group 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 Franciscan Medical Group, 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.** _____

TDC
THE DOCTORS CLINIC

CHI Franciscan Health
Our best care. Your best health.℠

Obtaining Verbal/Written Permission to Use or Disclose Protected Health Information

From time to time The Doctors Clinic, a part of Franciscan Medical Group, may wish to use or disclose your protected health information to individuals involved in your care for notification purposes. As stipulated by the Title 45, Section 164.10, we are permitted to make such uses or disclosures ***after we have obtained your verbal or written permission.***

The Doctors Clinic is authorized to: *(please check all that apply)*

☐ Notify or speak with my spouse regarding treatment or proposed treatment.
(please specify name): _____

☐ Notify or speak to my caregiver regarding treatment or proposed treatment.
(please specify name): _____

☐ Notify or speak to my family members, i.e., children, sister, brother, mother, father of treatment or proposed treatment.
(please specify name): _____

☐ Notify or speak to my friend regarding treatment or proposed treatment.
(please specify name): _____

☐ Notify my transportation service regarding my delivery or pick-up prior to or upon completion of my treatment.
(please specify name): _____

☐ Other (please specify): _____

How may we contact you with reference to your appointments, proposed treatment, follow-up appointments, billing questions/problems, surgery scheduling, lab testing, radiology, and other situations regarding your protected health information?

If I am not available, The Doctors Clinic may: *(please check all that apply)*

☐ Leave a message with my spouse or those members listed above.
☐ Leave a message on my answering machine, voice mail or cell phone.
☐ Call my place of employment and leave a message for me to return the call.
☐ Leave a message with my interpreter *(for foreign speaking patients)*
☐ Other: _____

_____ Date: «CurrentDate»
Patient/Guarantor Signature

_____
Print Name