EXPRESS Family CARE

BONSACK – CAVE SPRING

Patient's Information (Please complete with Patient's Full Legal Name):

First: _____ M: _____ Last: _____

Preferred Name: _____

Birthdate: _____ Home Phone No: _____ Cell Phone No: _____

Street Address: _____Apt. /Suite: _____

City: _____State: _____ Zip: _____ Social Security No: _____

Sex at Birth: Male/Female

Ethnicity: _____Email Address: _____

Marital Status: S / M / D / W Preferred Contact: Home / Cell / Email

Pharmacy Information:

Pharmacy Name: _____ Location: _____ Zip Code:_____

Insurance Information: (Please complete applicable fields as shown on card)

Insurance Company: _____ Policy Number: _____

Group Number: _____ Copay Amount: _____ Effective Date: _____

Policy Holder: Self / Spouse / Parent / Other (**IF NOT SELF, PLEASE COMPLETE THE FOLLOWING)**

Policy Holder First **Full** Name: _____M:_____ Last: _____

Policy Holder's Birthdate: _____

If you have a **Secondary Insurance** plan, please complete the following:

Insurance Company: _____ Policy Number: _____

Group Number: _____Copay Amount: _____ Effective Date: _____

Emergency Contact: *If patient is a minor, please list both Parents/Guardians*

Contact Name: _____Phone Number: _____Relationship: _____

Contact Name: _____Phone Number: _____Relationship: _____

In Case of emergency, do you allow the above person to receive your medical information? **YES / NO**

CONSENT FOR TREATMENT / AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH INFORMATION

Consent for Treatment / Care:

I consent to treatment and care by Express Family Care physicians and health care providers. I am aware that no one has made any guarantees about the results of my treatments, examinations, or procedures. I also give permission to Express Family Care to scan my image / take photographs or drawings of me for permissible treatment, payment, and health care purposes as long as consistent with policies and laws that protect my rights.

Authorization for Release of Confidential Health Information:

I give permission to Express Family Care to release any confidential medical information and records about me, my health, the health services provided to me, and payment for my health services that may be necessary for my treatment, to healthcare providers and facilities that need the information for my continued care, and for any purposes related to payment by me and/or a third party for services (to determine eligibility, to process an insurance claim, for utilization and quality review, and for billing and collection purposes, as necessary to obtain payment); and or continuity of care purposes with my PCP. For more detailed information about the way my information may be used or released, I can read Express Family Care's privacy practices.

Authorization to Disclose Protected Health Information to Family Member or Other Individual:
Do you wish to designate a family member or other individual with whom Express Family Care may discuss your medical condition/treatment/lab results with? If yes, whom?

_____ (**PATIENT / GUARDIAN INITIALS**) I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the following:

Name	Relationship	Contact Number

I understand that I have the right to revoke this Authorization for Release of Confidential Health Information. My revocation will not be effective until delivered in writing to Express Family Care. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. A copy of my revocation shall be maintained. I understand that information disclosed by this authorization may be re-disclosed by the recipient and would no longer be protected by federal privacy regulations. Express Family Care will not condition treatment on whether I sign this Authorization for Use and Release of Information unless the circumstances under which such conditioning is permitted by law, are

applicable, and are set forth in this authorization. This authorization will be effective for one year after the date it is signed; however, this authorization will not expire for services or claims processing for visits occurring while this consent was in effect.

PATIENT / GUARDIAN SIGNATURE: _____ DATE: _____

Authorization to Disclose Protected Health Information Via Electronic Mail (E-mail)

From time to time, it may be efficient for Express Family Care to send communications to you via e-mail. Please understand that there are risks of unintentional disclosure when using unencrypted e-mail, and confidentiality cannot be guaranteed. By signing below, you authorize Express Family Care to use unencrypted e-mail to send information to you that may contain your protected health information. (Note that this authorization permits Express Family Care to *send* you information via email; Express Family Care will not receive your health information via e-mail.)

PATIENT / GUARDIAN SIGNATURE: _____ DATE: _____

PATIENT FINANCIAL RESPONSIBILITY

Financial Responsibility:

I understand that an insurance company may not pay the full amount of my charges, and I am responsible (as a patient, spouse, or the parent/guardian of a minor child) to Express Family Care for the amount not paid. I understand that If I do not have health insurance or have not provided current or accurate insurance information, I am responsible for payment of all charges. I agree that if I have overpaid for any services, the overpayment may be applied to pay any outstanding charges on my, my minor children's, or my spouse's account(s).

Authorization for Medicare/Insurance Assignment and Payment Request:

I authorize Express Family Care to bill directly, and be paid directly by, Medicare/my insurance company. I assign the right to all health and liability insurance benefits otherwise payable to me to Express Family Care. I have given my social security number voluntarily. I understand I may withdraw this authorization in writing at any time. I authorize Express Family Care to release all records required to act on these requests.

By signing below, I acknowledge that I have read, understand, and agree to the Patient Financial Responsibility provisions above. I have received a copy of this form if requested.

PATIENT / GUARDIAN SIGNATURE: _____ DATE:_____

RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge I have been presented with a copy of Express Family Care's Notice of Privacy Practices (HIPAA), detailing how my health information may be used and disclosed as permitted under federal and state law. I understand that I may contact Express Family Care if I have any questions about the content of the Notice.

PATIENT / GUARDIAN SIGNATURE: _____DATE: _____