Patient Profile

Doctor: _____

PATIENT INFORMATION

Name: _____ **Patient ID #:** _____ **Sex:** ☐ M ☐ F

Address: _____ **Date of Birth:** _____

_____

City,State: _____ **Phone:** _____ ☐ Home ☐ Work ☐ Cell

Referring Dr: _____ **Phone:** _____ ☐ Home ☐ Work ☐ Cell

CONTACTS

Name: _____ **Relation:** _____ ☐ H ☐ C **Phone:** _____

Name: _____ **Relation:** _____ ☐ H ☐ C **Phone:** _____

Name: _____ **Relation:** _____ ☐ H ☐ C **Phone:** _____

GUARANTOR INFORMATION

☐ **Same as Patient** **Employer:** _____

Name: _____ **Phone:** _____

Address: _____ **Phone:** _____

_____ **SSN #:** _____

City,State: _____ **Date of Birth:** _____

PRIMARY INSURANCE

☐ **Same as Patient** ☐ **Same as Guarantor** ☐ **Other**

Carrier Name: _____ **Insured ID:** _____

Insured Party: _____ **Policy Group:** _____

Insured Phone: _____ **SSN #:** _____

Relationship to Patient: _____ **Date of Birth:** _____

SECONDARY INSURANCE

☐ **Same as Patient** ☐ **Same as Guarantor** ☐ **Other**

Carrier Name: _____ **Insured ID:** _____

Insured Party: _____ **Policy Group:** _____

Insured Phone: _____ **SSN #:** _____

Relationship to Patient: _____ **Date of Birth:** _____

PATIENT EMPLOYMENT

☐ **Employed** ☐ **Retired** ☐ **Unemployed** ☐ **Other**

Employer: _____ **Phone:** _____

09/09/2014

Mendakota Pediatrics General Consent Form for Medical Services
AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient (and/or Responsible Party) confirming this authorization to release PHI

Patient Name: Phone ☐ Home ☐ Work ☐ Cell

Address: Pat Id:

Email Address: _____

Responsible Party Name: _____ Relationship to Patient: _____

CHANGING YOUR MIND ABOUT THIS AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at this clinic. I understand that, in the event that my insurance carrier requires this authorization, and I have refrained from signing, I may be responsible to pay for services rendered.

Initial _____

Consent to Treat

I consent to and authorize the physicians, nurses and the other healthcare providers at MENDAKOTA PEDIATRICS to perform appropriate healthcare examinations, treatment, and diagnostic testing or medication administration as deemed medically necessary by their professional judgement. I know that there are some risks with all medical treatments and procedures and I understand that no one can guarantee how well treatments or procedures will work.

Assignment of Benefits/Payment for Services

I authorize payment of any and all benefits to MENDAKOTA PEDIATRICS. I know that I must pay for any charges for my care that are not covered by my insurance, health plan, or government programs. I realize I must cooperate with MENDAKOTA PEDIATRICS to get payment for my care. If I am eligible for payment from more than one type of coverage, MENDAKOTA PEDIATRICS will return any extra payments to the payer. If I have an upaid bill at MENDAKOTA PEDIATRICS, any refunds due to me will be put on my unpaid bill. If there is money left over after my bill is paid, I will get a refund from MENDAKOTA PEDIATRICS.

Release of Information

I consent to and authorize MENDAKOTA PEDIATRICS to use and disclose my protected health information for:

- Treatment
- Payment
- Healthcare Operation Purposes, including care coordination and quality assessment and improvement activities.

Releases for these purposes may be made to insurance companies, health plans, government programs, e-prescriber databases, payer network organizations, including clinically integrated networks and/or accountable care organizations in which my provider participates, and the other healthcare providers involved in my care and treatment. Additionally, I consent to and authorize my insurance company to share my protected health information for the purposes stated above to MENDAKOTA PEDIATRICS or a clinically integrated network or accountable care organization in which MENDAKOTA PEDIATRICS participates.

Patient Rights and Privacy Practices

You and your family's rights and our privacy practices are posted in main areas within MENDAKOTA PEDIATRICS. Your signature acknowledges receipt of our Notice of Privacy Practices. If you have any questions concerning your rights and/or our privacy practices, please contact your care provider or the MENDAKOTA PEDIATRICS Privacy Officer.

Other Individuals Authorized to Consent to Treament

In addition to the legal guardians of the patient, the following persons are authorized to consent to recommended medical care for my child: name and relationship to patient (e.g., grandma, grandpa, daycare provider, etc.)

Name:	**Relationship to child:**
1. _____	_____
2. _____	_____

My signature here means I have read this information and I understand it. This consent is valid until revoked in writing.

Patient Name: _____ **Date:** _____

Signature: _____ **Print Name:** _____

Relationship to Patient: _____ **Name of Interpreter (if used):** _____

Telephone consent obtained by (Name/Date/Title): _____