DRY CREEK MEDICAL GROUP, INC.

Patient Information Sheet

PATIENT INFORMATION

Name: ____________________ SSN#____________________ DOB:________

Address ________________ City______________ State__________ Zip__________

Home Phone#____________________ Cell Phone#____________________

Other #____________________ E-Mail ____________________

GUARANTOR INFORMATION

Name: ____________________ SSN#____________________ DOB:________

Home Phone#____________________ Cell Phone#____________________

INSURANCE INFORMATION

Primary Insurance Name: ____________________ Phone #:____________________

Insurance Address____

ID Number____________________ Group Number____________________

Policy Holder: ____________________ SSN #______________ DOB____________

Secondary Insurance Name: ____________________ Phone #:____________________

Insurance Address____

ID Number____________________ Group Number____________________

Policy Holder: ____________________ SSN #______________ DOB____________

EMERGENCY CONTACT PERSON

Name: ____________________ Relationship to patient____________________

Address ____ Phone #:______________

PATIENT SIGNATURE:____ **DATE:** __________

(PLEASE CALL 24 HOURS IN ADVANCE TO CHANGE APPOINTMENT TO AVOID $30.00 CHARGE)

Financial Responsibility

Patient: ____ ______________
Last Name First Name MI DOB

ASSIGNMENT OF BENEFITS: I request that payment of authorized insurance companies be made on my behalf to DRY CREEK MEDICAL GROUP, INC. for any services furnished to me by my physician (Barbara Morlan M.D., Tony Reid P.A.C., Hector Ramos M.D., and Karen Segovia N.P). I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent and/or any insurance company any needed to determine these benefits or benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay this claim. In insurance carrier assigned cases, the physician or supplier agrees to accept the charge determination of the Insurance carrier as the full charge, and the patient is responsible for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination of the insurance carrier.

Further use or disclosure to the information being released beyond the specific limits of this consent is prohibited.

______________________________________ ______________________________
Signature of Patient or Authorized Person Relationship to Patient

____
Date

FINANCIAL AGREEMENT: I, undersigned, agree whether I am signing as an agent as the patient, that I am financially responsible for any charges not covered by the insurance assignment(s). It is understood and agreed by all parties that of DRY CREEK MEDICAL GROUP, INC. is contracted with my insurance carrier, I am only responsible for my co-payment and/or deductible as contracted. If there is no insurance coverage/or eligibility I will be responsible for all charges.

Further use or disclosure to the information being released beyond the specific limits of this consent is prohibited.

______________________________________ ______________________________
Signature of Patient or Authorized Person Relationship to patient

____
Date

HIPAA COMPLIANT AUTHORIZATION FOR THE RELESE OF THE PATIENT

INFORMATION PURSUANT TO 45 CFR 164.508

TO:____

NAME OF HEATH CARE PROVIDER/PHYSICIAN/FACILITY/MEDICARE CONTRACTOR

____

STREET ADRESS

____

CITY, STATE AND ZIP CODE

RE: PATIENT NAME: __________________________________

DATE OF BIRTH: _______________

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

- All medical records, meaning ever page in my record, including but not limited to: Office notes face sheets, history and physical, consultations notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker, records, clinic records, treatment plans, admission records, discharge summaries, request for reports of consultations, documents, correspondence, and all test results.

- All physical, occupational and rehab requests, consultations and progress notes.
- All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records, radiology records including MRI CT MRA EMG and bone scan
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs
- All billing records including all statements, insurance claim forms, itemized bills, and records of billing

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AID's), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purpose:

____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

____

Name of representative

____

Street address

____

City, state and zip code

I understand the following: see CFR 164.508 (c) (2) (i-ii)

A. I have the right to revoke this authorization in writing at any time, expect to extent information has been released in reliance upon authorization
B. The information released in response to this authorization may be re-disclosed to other parties
C. My treatment of payment for my treatment cannot be conditioned on the signing of this authorization

Any facsimile, copy of photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

______________________________	____________________
Signature of Patient	Date
____	____________________
Name and relationship of legally authorized representative to patient	Date
______________________________	____________________
Witness Signature	Date

Release of Information

PATIENT: ____ ______________

Last Name First Name MI DOB

FOR DISCUSSION WITH FAMILY OR FRIENDS

I hearby give authorization to release information and/or discuss my medical condition including my protected health information such as psychological or psychiatric impairment, drug and/or alcohol abuse, or Acquired Immuno-deficiency Syndrome (AIDS), or tests for infection with Human Immunodeficiency virus (HIV) with person(s)/entities listed below:

Person/entity name	Relationship to Patient (or other) description
______________________	______________________
Person/entity name	Relationship to Patient (or other) description
______________________	______________________
Person/entity name	Relationship to Patient (or other) description

REQUEST RECORDS FROM THE FOLLOWING

Physician's Name	Medical Group Name	Phone Number
______________	______________	__________
Physician's Name	Medical Group Name	Phone Number
______________	______________	__________
Physician's Name	Medical Group Name	Phone Number

This authorization can be revoked at any time upon my written request.

______________________________ ______________________

Patient's Signature **Date Signed**

Notice of Privacy Agreement

DRY CREEK MEDICAL GROUP, INC. has provided the Notice of Privacy packet on ___________.

I have read and understood all terms included in the packet and was given the option to receive a personal copy.

____
Patient's Name

______________________________ ______________________________
Patient's Signature Date

______________________________ ______________________________
Witness Signature Date