PATIENT INFORMATION

DATE: _____ PHARMACY PHONE #: (____)_____

PATIENT'S FULL NAME: _____ DOB: _____ AGE: _____

SOCIAL SECURITY #: _____ MARITAL STATUS __S __M __D __W SEX: _____

HOME ADDRESS: _____ zip_____

HOME TEL. _____ CELL PH. # _____ _WORK # _____

EMAIL ADDRESS: _____ _____

PATIENT'S SPOUSE _____ __PHONE #_____

EMERGENCY CONTACT _____ _PHONE #_____

PATIENT'S EMPLOYER/SCHOOL: _____ PHONE # _____

IF PATIENT IS A MINOR, FILL IN RESPONSIBLE PARENT OR GUARDIAN INFO:

MOTHER'S NAME: _____ PHONE # _____
ADDRESS: _____
EMPLOYER'S NAME: _____ PHONE # _____

FATHER'S NAME: _____ PHONE # _____
ADDRESS: _____
EMPLOYER'S NAME: _____ PHONE #
_____

GUARDIAN NAME: _____ PHONE # _____
ADDRESS: _____
EMPLOYER'S NAME: _____ PHONE # _____

I, THE UNDERSIGNED, OR AS THE PARENT OR LEGAL GUARDIAN OF THE UNDERSIGNED AUTHORIZE ANTOINE CLINIC PA AND ASSOCIATES TO RENDER MEDICAL TREATMENT TO MYSELF OR THE PATIENT ABOVE FOR WHOM I AM RESPONSIBLE.

PRINT NAME: _____ DATE: _____

SIGNATURE: _____

INSURANCE INFORMATION

PAYMENT FOR SERVICES RENDERED IS TO BE MADE AS FOLLOWS:

"I REQUEST THAT PAYMENT OF AUTHORIZE INSURANCE BENEFITS TO BE MADE TO ANTOINE CLINIC PA AND ASSOCIATES FOR ANY SERVICES OR ITEMS FURNISHED TO ME BY THE PHYSICIAN OR SUPPLIER. I AUTHORIZE THE PRACTICE TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION (HCFA/CMMS), MY INSURANCE CARRIER, AND/OR ITS AGENTS APPROPRIATE INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES, IN ACCORDANCE WITH HIPPA GUIDELINES RELEASE OF OTHER INFORMATION REQUIRES SPECIFIC RELEASE AUTHORIZATION. I AM FINANCIALLY RESPONSIBLE FOR APPROPRIATE DEDUCTIBLES, COPAYMENTS, AND NON COVERED ITEMS (WHICH HAVE BEEN EXPLAINED TO ME FROM THE INFORMATION SUPPLIED BY MY CARRIER). IF THIS ACCOUNT HAS TO BE TURNED OVER TO AN ATTORNEY DUE TO DELIQUENCY OR NON PAYMENT, I WILL BE RESPONSIBLE FOR ALL COSTS COLLECTION INCLUDING THE COURT COSTS AND REASONABLE ATTORNEY FEES."

_____ _____

SIGNATURE OF BENEFICIAY OR PERSON SIGNING FOR BENEFICIARY DATE SIGNED

PRIMARY INSURANCE INFORMATION:

INSURANCE COMPANY NAME: _____

POLICY HOLDER: _____ POLICY HOLDER DOB: _____

INSURED SSN: _____ RELATIONSHIP TO THE PATIENT: SELF SPOUSE CHILD

POLICY # _____GROUP # _____ PHONE # _____

SECONDARY INSURANCE INFORMATION:

POLICY HOLDER: _____ POLICY HOLDER DOB: _____

INSURED SSN: _____ RELATIONSHIP TO THE PATIENT: SELF SPOUSE CHILD

POLICY # _____GROUP # _____ PHONE # _____

Consent to Use and Disclose Protected Health Information

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORAMTION

Your protected health information will be used by Antoine Clinic PA and associates or disclosed to others for the purpose of treatment, obtaining payments, or supporting the day-to-day health care operations of the practice.

THE NOTICE OF PRIVACY PRACTICES

Antoine Clinic PA and associates are required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" brochure provided to you. Please review it carefully.

YOU MAY PLACE RESTRICTION ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION

You may request a restriction on the use or disclosure of your protected health information. However, Antoine Clinic PA and associates may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative or Office Manager if you would like additional information or clarification.
It is a violation of the Federal privacy standards if Antoine Clinic PA and associates agrees and fails to comply with your request. The restriction requested will not affect use and disclosure of your information before the date of your request. If you still have any question after reviewing the Notice of Privacy Brochure, please consult with the practice representative or Office Manager at the location and contact information listed on the back of the Brochure.

YOU MAY REVOKE THIS CONSENT AT ANYTIME

You may revoke this consent at any time. However, Antoine Clinic PA and associates requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the date of your request.

CHANGES TO PRIVACY PRACTICES

Antoine Clinic PA and associates reserve the right to change and modify the privacy practices outlined in the Notice of Privacy Brochure. Antoine Clinic PA and associates will notify you of any change of privacy practices by mail or at your next appointment or any other pre-approved method that you request.

SIGNATURE

I have reviewed this consent form, received the Brochure entitled "Notice of Privacy Policies and Practices" and give my consent to Antoine Clinic PA and associates to use and disclose my health information in accordance with this consent and the notice provided.

_____ _____
Name of Patient (Print or Type) Signature of Patient/ Date

_____ _____ _____
Patient Representative (Print or Type) Relationship Signature of Representative/Date