Moore Family Practice, LLC

Legal Name: _____ DOB: _____

Sex:_____Sexual Orientation:_____Gender Identity:_____

Race_____Ethnicity:_____Language:_____

Marital Status:_____SSN:_____

Address:_____

City, State_____ZipCode:_____

Home Phone:_____WorkPhone:_____

Cell Phone:_____Email:_____

Parent/Guardian Name:_____Phone:_____

Emergency Contact:_____

Phone:_____Relationship to patient_____

Primary Insurance:_____Policy Holder_____

Relationship_____DOB:_____**W**ho may have access to my Medical Records: (this allows us to release your medical information to anyone you list below)

_____

If I am not available the following individual(s) may bring my minor child to Moore Family Practice, LLC for Healthcare:

_____

I Request/ Authorize Moore Family Practice , LLC to furnish the medical care necessary for my condition and understand that no guarantees as to the results have been made to me. I understand that I am financially responsible for all charges whether or not paid by insurance for the services rendered to me. I hereby authorize the release of all information necessary to secure payments or benefits.

Patient Signature_____Date_____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical record and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, payment, or health care operations, in order to provide health care the is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment, or heath care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you, should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in the document, at some future time you may request to refuse all or part of you PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

If your account goes to collections you will be responsible for the balance due plus an additional 35% of amount owed.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.SEPYou have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name_____Signature:_____
Date: _____