ALLMED MEDICAL GROUP
Better Care for a Better Life

Name

Address

Social Security #: Gender Date of birth

Home# Mobile# Email:

Parent/Guardian:

Employer Name: Not employed ☐

Employer Address Work phone

Emergency Contact Name:

Emergency Relationship Emergency Phone#

Pharmacy Name: City

Pharmacy# Pharmacy Fax#

Insurance information

Primary Insurance Company

Group # ID # Phone #

Name of the policy Holder

Relationship

Secondary Insurance

Group # ID # Phone #

Name of the policy Holder

Relationship

Medicare ID# Medicaid ID# SEQ #

Whom should we thank for your referral?

CONSENT, ASSIGNMENT, AND RELEASE FORM

CONSENT FOR MEDICAL TREATMENT:

I voluntarily present to AllMed - Medical Group and consent to the treatment of the physician on duty and whomever they may be designated as their assistant, associate, treating physician, and patient care staff to provide for my care. Such care may include, but it's not limited to, diagnostic procedures, radiological evaluations, and administration of medications considered advisable in my diagnosis, treatment, in course of my care. I acknowledge that no guarantee can be made or has been made as to the results of treatment or examinations, and I understand that all medical treatments contain inherent risks.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE:

In consideration of service provided, I hereby assign and transfer to AllMed - Medical Group all rights, which I have against an insurance company or third-party payers, for payments of charge for services provided by AllMed - Medical Group to me or two one of my dependants. I authorized the mentioned payments to be applied to any unpaid balance for which I am responsible.

I understand that I am responsible and will pay for the portion of my bill not covered by the insurance companies or third party payers. I agreed to pay the account in full upon received of my billing statement unless payment arrangements are made with AllMed - Medical Group, in advance. It is AllMed - Medical Group policy, and I was informed, that any insurance copays and deductibles or balance of a bill owned by those without insurance are due at the time of the service.

GOVERNMENT COMPLIANCE:

In compliance with the recently enacted Patient Protection and Affordable Care Act and the Stark law, AllMed - Medical Group must inform me, that there are other options pertaining to lab diagnosis and radiological service. Specifically, it should be noted that AllMed - Medical Group, presented voluntary information for any medical needs and that as part of the evaluation of the condition and any required treatments the physician on duty may determine that particular laboratory diagnostic and radiographic tests may be required. I was made aware that AllMed - Medical Group offers many of these services on-site as a convenience to the patients.

If any patients would like to have their exams/tests conducted at another location AllMed - Medical Group, will provide a referral form. I understand it is my responsibility to seek appointments and request results to be emailed/fax to the AllMed - Medical Group.

RELEASE AND USE OF PATIENT INFORMATION:

I authorize the release of any medical records, information, treatment and advice, and specific health information to:

1. Treating physicians on staff at AllMed - Medical Groupand their staff, agents, or another health care facility if directed transferred to another facility is required, and to my primary care physician or any consultants for follow up care.
2. An employer. This may include my medical history physical, laboratory, and diagnostic tests, including drug screenings.
3. Insurance company or any other third party payor and their agents as well as any review organizations or government agency to determine eligibility or available benefits, obtaining payments for services provided, and ensuring government compliance. Educational or scientific institutions.
4. Health care professionals in training, internal quality improvement, risk management, and legal counsel when is judged that my ongoing medical care, medical research, quality improvement health care education or science will benefit; for any purpose.
5. I understand that if I refused to authorize access to my medical records for coordination of care my treatment could be adversely affected and that I could be held liable for the full cost of service provided by all Med Medical Group.
6. I understand this information may contain my personal medical history, physical, and treatments. Additionally, any radiologic and laboratory results, including results in reference to alcohol abuse, mental health, or infections disease including HIV, or hepatitis, in or other infectious diseases. I understand that
7. I have the right to revoke these authorizations

Printed patient name:

Patient/Parent/Guardian signature: **Date**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR FAMILY OR OTHER INDIVIDUALS:

Under the federal government privacy rules implemented through the health insurance portability and accountability act of 1966, for your physician or the staff of AllMed - Medical Groupto provide copies and or discuss your condition slash exam/procedures/ X Rays with members of your family or other individuals that you designate other than your primary care doctor or specialist, we must obtain authorization before doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

1) I authorize AllMed - Medical Group to release any information including verbal information copies of Xrays and medical paperwork concerning my medical care to the following individuals:

   Name Relationship phone#

   Name Relationship phone#

2) I authorize AllMed - Medical Group to leave a detailed message on the phone number/email on file.

I DO NOT authorize PLEASE INITIAL

1) I ***do not*** authorize anyone from AllMed Medical Group to release any information concerning my care to any individual. _____ ☐

2) I ***do not*** authorize AllMed - Medical Group to leave a detailed message on any of my answering machine or voice mails. _____ ☐

3) I acknowledge that by choosing this option that I do as a patient assume full responsibility for contacting AllMed - Medical Groupfor any results of testing.

Printed patient name:

Patient/Parent/Guardian signature: **Date**

AUTHORIZATION TO DISCUSS FINANCIAL INFORMATION: YES ☐ NO ☐

Under federal government privacy rules implemented through the healthcare insurance portability act of 1966, AllMed - Medical Group must obtain your authorization to discuss financial information with members of your family or other individuals that you designate other than the insurance company or third party payers and their agents. I authorize AllMed - Medical Groupto verbally discuss financial information with:

Name	Relationship	phone#
Name	Relationship	phone#

ASSIGNMENT OF BENEFITS: YES ☐ NO ☐

I attest I assign AllMed - Medical Group and/or surgical benefits including major medical benefits to which I am entitled including, Medicare, HMO plans, and commercial insurance to AllMed - Medical Group. This assignment will remain in effect until provoked by me in writing. I hereby authorize the above to release information to secure payment on my behalf.

RECEIPT OF HIPAA PRIVACY NOTICE: YES ☐ NO ☐

I acknowledge receipt of the notice of privacy rights we detail information about how AllMed - Medical Group may use and disclose my protected health information. I understand that all Med Medical Group reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

HEALTH CARE PROXY NOTICE

I acknowledge receipt of the Health Care Proxy notice. **YES** ☐ **NO** ☐

I decline to proceed with the form. **YES** ☐ **NO** ☐

I would like to have a HCP form on file at AllMed Medical Group. **YES** ☐ **NO** ☐

Printed patient name:

Patient/Parent/Guardian signature: **Date**