Patient name:_____ **SS#**_____
Last First MI

Birthdate:___/___/_____ **Race:** __White__Black__Hispanic__Asian__Other **Language:** __English__Spanish__Other

Marital Status: __M__S__D__W **Sex:** ___M ___F **Home Phone**:_____ _____

Cell Phone:_____ **Email**:_____

Address:_____
Street City State Zip

Emergency Contact:_____ **Employer**:_____
Name Phone

Responsible Party/Insurance Subscriber Information

Name:_____ **SS#**:_____

Birthdate:___/___/_____ **Relationship to patient**:_____

Address:_____

Primary Insurance:_____ **Secondary Insurance**:_____

Authorization for release of information/consent to medical treatment

I hereby authorize Boyett Health Services, Inc. and my doctor to furnish information to my insurance carrier concerning my illness and/or treatment. I hereby voluntarily consent to medical care, which may include diagnostic procedures and such medical treatment as my physician and/or provider at this clinic considers being necessary. I understand that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of the examination or treatment at this clinic or by its providers.

Insurance Assignment of Benefits

I request payment of my medical services rendered by Dr. Brent Boyett and/or any provider at this clinic be made directly to Boyett Health services, Inc. I understand that I am responsible for such fees that are not paid by my insurance carrier within a reasonable time. I am aware that certain services may not be covered by my insurance carrier, and I will be responsible for any such services. In the event any charges remain unpaid by my insurance carrier of me after a reasonable time, then I agree I will be responsible for collection including agency fees, attorney's fees and/or court cost.

Financial Responsibility

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account(s) for any professional services rendered. I understand that full payment is due upon services rendered, unless previous arrangements have been made. I agree that should my account(s) be referred to a collection service and/or an attorney for collection, I will be responsible for all reasonable collection service charges and/or attorney fees, court costs, and other related expenses. I further agree that I will at no time file for a waiver of exemption against any type of legal seizure of personal property involved in the collection of delinquent payments. My signature affirms that I have read and understand the above agreement.

Signature:_____ Date:____/____/_____

AUTHORIZATION FOR THE RELEASE
OF PATIENT INFORMATION

Please understand that it may be necessary for us to release some or all of the information contained in your medical records to other physicians, nurses, and/or healthcare providers that you have seen or received prescriptions from, or physicians from which we must seek medical expertise concerning your care . At times, other providers assist us assessing a patient's condition, screening for potential problems or providing consultation under certain circumstances. All healthcare providers are required by law to keep your information confidential.

Due to the increased awareness of quality care it may be necessary to disclose information regarding your care to healthcare agencies, both private and governmental. Your insurance company and/or your self-insured employer are such agencies. Regarding the information going to your employer other than information needed to verify your insurance coverage; the data released will consist of statistical information only.

Also, at times it may be necessary for the physician/healthcare provider to contact you regarding your healthcare issues, if you are unavailable or cannot be reached:

_____ I do not wish to have test results or other medical information released to any person other than myself.

_____ I do wish to have test results and other medical information released to the following person(s) (these individuals are people other than medical personnel):

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

It is the responsibility of the patient to notify this office of any changes to the above information if changes do occur. The patient must fill out another authorization with this new information.

_____ _____
Patient Signature Date

_____ _____
Printed Name Social Security Number

_____
Witness

PATIENT CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that the organization has the right to change its *Notice of Privacy Practice* from time to time and that I may contact the organization at any time at the address below to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name _____

Signature _____

Relationship to Patient _____

Date _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that the organization has the right to change its Notice of Privacy Practice from time to time and that I may contact the organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Signature _____

Relationship to Patient _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason: