FAMILY CONVENIENCE CLINIC

ALL KIDS "R" US Medical Clinic

PATIENT INFORMATION

Patient Name_____ DOB_____ Male ☐ Female ☐

Home Address_____ City/State/Zip_____

Cell Number_____ Home Number_____ Email Address_____

Social Security Number_____ Race_____ ☐ I choose not to answer Religion_____ ☐ I choose not to answer

Primary Language Spoken_____ Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse/Parent Name_____ Spouse/Parent Phone Number_____

INSURANCE INFORMATION: ☐ I do not have insurance ☐ My employer is paying for my visit – Employer _____

Primary Insurance_____ Policy Holder Name _____ Policy Holder DOB_____

Secondary Insurance_____ Policy Holder Name _____ Policy Holder DOB_____

Agreement: All professional services rendered are the financial responsibility of the patient and/or legal guardian. Payment is expected upon the provision of services. For insured patients, we are pleased to assist in the filing of your insurance claims.

Consent to release information: By signing below, I hereby consent to my insurance carrier releasing all necessary information to Family Convenience Clinic and/or All Kids R Us regarding the status of my claims.

Assignment of benefits: My signature below authorizes Family Convenience Clinic and/or All Kids R Us to furnish information to my insurance carrier concerning my medical history, illness and treatments or procedures. I authorize my insurance carrier to pay directly to Family Convenience Clinic and/or All Kids R Us all benefits to which I and/or my dependent may be eligible for the provision of health care services.

It is our policy to verify benefits and eligibility to estimate your payment portion at the time of service. However, there is no guarantee from the insurance company of their payment amount. We may not know the exact amount due until the claim has processed. At this point, there may be more due to your account. In this event, we will mail you a statement, and appreciate your prompt payment.

My signature indicates that I have read, understand, and agree to all the provisions above.

Patient/Legal Guardian Signature _____ Relationship to Patient _____ Date _____

AUTHORIZATION FOR CONSENT FOR TREATMENT

I consent to medical treatment(s) and/or necessary procedures for the above patient. I understand that medical treatment(s) and/or procedure(s) will be discussed with me. I also understand I have the option to refuse any medical treatment(s) and/or procedure(s). Should I refuse advised medical treatment(s) or procedure(s) I consent to sign a refusal of treatment if applicable

Patient/Legal Guardian Signature _____ Relationship to Patient _____ Date _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

I authorize the following person(s) to be able to obtain PHI from my medical record via telephone until revoked by me in writing:

Name:_____ Relationship:_____ Phone Number:_____

Name:_____ Relationship:_____ Phone Number:_____

☐ I choose not to release any PHI to anyone other than myself except as required by law

Patient/Legal Guardian Signature _____ Relationship to Patient _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of Family Convenience Clinic and/or All Kids R Us' current Notice of Privacy Practices.

Patient/Legal Guardian Signature _____ Relationship to Patient _____ Date _____