# MAC CLINIC – HWMC: PATIENT INFORMATION AND CONSENT FORM

Date: ____/____/________

Patient Name: ___________________________________________ SS. # ______/_____/__________ DOB: ____________

Address: ________________________________ City: _____________________ State: ________ Zip: ________________

Home #: (______) ______ - __________ Work #: (______) ______ - __________ Gender: M / F Marital Status: S M D W

Race: ___________ Language: _____________ Ethnicity: Hispanic/Latino Non-Hispanic/Latino Nationality: __________

Email Address: _______________________________________________________

REASON FOR THIS APPOINTMENT:: ▫ Motor Vehicle Accident ▫ Work-Related Issue ▫ Personal Medical Issue

**If this visit is a Motor Vehicle Accident or Work-Related Issue, please let our staff know to give you the appropriate forms so you are not billed directly for these services.**

DO YOU HAVE HEALTH INSURANCE? YES / NO (Please supply the receptionist with your Insurance Card(s)

NAME OF POLICY HOLDER: ______________________________ POLICY HOLDER SS. # ______/_____/__________

BIRTH DATE: ____/____/________ RELATIONSHIP TO PATIENT: __________________________________

ADDRESS AND PHONE # (IF DIFFERENT):
____________________________________________________________________________________________________

CONSENT TO TREATMENT AND MEDICAL RECORDS:

I have given permission to MAC Clinic – HWMC, and their staff, to perform the following procedures/therapy deemed necessary: health history, physical exam, diagnostic procedures, x-rays, imaging studies, ImPACT concussion testing, venipuncture (drawing blood for lab tests) and treatment for my injury/illness. If I should become ill while undergoing treatment, I give MAC Clinic – HWMC, and their staff, my permission to administer treatment which they consider necessary for my well-being.

I understand that the information regarding the results of my physical exam, diagnostic procedures, and/or nature of my illness may be released to the insurance carrier providing coverage to me. I understand that it is ultimately my responsibility to be aware of the benefits under my insurance plan, and understand that should I have special requests regarding facilities to be utilized for diagnostics tests/treatment, I should communicate those at the time of my visit(s). I consent to have my medical information transferred to any physician and/or health care institution that I am referred to by MAC Clinic – HWMC. I consent to authorize MAC Clinic – HWMC to request any medical records from other health care providers.

I understand medical information will be communicated to a designated representative of my employer ONLY if this is a Worker Compensation or an employer paid physical examination service.

My signature or mark indicates that I have read and understood this consent form and consent to treatment.

**** Patient/Guardian Signature: **X**__________________________________________ Date: ___________________

(Signature required)

Name of Parent or Guardian (please print) ____________________________________ SS# : ________________________

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE**

**MAC CONCUSSION CLINIC – HWMC**

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of MAC CLINIC – HWMC's "NOTICE OF PRIVACY PRACTICES," revision date April 14, 2003.

As required by the Privacy Regulations, I am aware that MAC CLINIC – HWMC has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

I have been notified of the MAC Clinic – HWMC policy regarding "Request for Restriction" of my Protected Health Information, "Request for Alternative Communications" of my Protected Health Information and the procedure for making an objection to any item in the "Notice of Privacy Practices;"

**I understand that this office is not required to honor any requested changes to the "Notice of Privacy Practices."**

**X** ________________________________________ ____________________________

Signature Date

________________________________________________

Print Name

If not signed by the Patient, please indicate your relationship to the Patient:

____________________________________________________

(**FOR OFFICE USE ONLY)**

Signed form received by: _________________________________________________ Date: ________________________

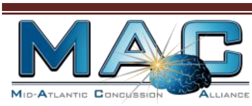
Good faith effort to obtain receipt: (Describe)

___________________________________________________________________________________________________

___________________________________________________________________________________________________

______THIS IS A DIRECT ASSIGNMENT OF MY BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charge over and above this insurance payment, even if my insurance carrier claims that MAC Clinic – HWMC must accept my contract provider remuneration, by accepting the assignment of benefits.

I also authorize the release of information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.



I authorize the Doctor to initiate a complaint to the Insurance commissioner for any reason on my behalf.

______ I DO NOT HAVE HEALTH INSURANCE – I AGREE TO MAKE PAYMENT IN FULL FOR ALL PROFESSIONAL SERVICES RENDERED TO ME.

I realize that the concussion clinic's services are important and the clinic's schedule has limited appointments. I agree to pay a $50 no-show or cancellation fee if I do not call at least 24 hours in advance to cancel my appointment or if I do not show up for my scheduled appointment.

*I understand that unpaid balances over 45 days will be subject to a 1.5% monthly service charge or $5 monthly billing fee, whichever is greater. Any balances unpaid after 60 days may be subject to action by a Collection Agency. Should the account be sent to Collections, a 40% surcharge on the balance will be charged to cover the costs of collection.*

Dated at MAC Clinic – HWMC, this __________________ day of ______________________, 20______

✕_______________________________________ ✕_______________________________________

Signature of Policyholder of Designee (REQUIRED) Signature of Claimant, if other than Policyholder (REQUIRED)

**CREDIT CARD/ DEBIT CARD AUTHORIZATION**

It is our policy to require all patients to place a valid credit or debit card on file at the time of their visit for balance billing purposes. Upon receipt of the explanation of benefits from your insurance company, any unpaid portion of your claim will be billed to the credit card you have on file. **You will not receive a statement prior to the debiting of your card.**

Your card information will be stored on a secure server, in an encrypted manner compliant with PCI DSS, by our credit card company. In the unlikely event that your credit card is billed in error, we will promptly be issued a credit.

I hereby authorize MAC Clinic – HWMC to charge any and all outstanding balances to my credit/debit card. I understand that I will receive a statement of account showing this charge, along with a copy of the credit card receipt.

**Patient Name:** _________________________________________________Date: _________________________

Name of Credit Card Holder: _________________________________________________

Signature of Credit Card Holder: **X** _______________________________________________

**MEDICARE PATIENTS ONLY**: I UNDERSTAND THAT MEDICARE MAY NOT COVER SOME SERVICES WHICH MY PHYSICIAN BELIEVES ARE NECESSARY FOR MY TREATMENT, OR SERVICES WHICH ARE NOT CONSIDERED MEDICALLY NECESSARY, BUT WHICH I MAY REQUEST TO BE PERFORMED ANYWAY. THESE SERVICES INCLUDE, BUT ARE NOT LIMITED TO:PRE-OPERATIVE EXAMINATIONS, VACCINATIONS, PULSE OXIMETRY, EKG'S.

SHOULD MEDICARE DENY PAYMENT FOR SERVICES CONSIDERED "ROUTINE" OR NOT "MEDICALLY-NECESSARY," I UNDERSTAND THAT I WILL BE PERSONALLY RESPONSIBLE FOR PAYMENT. THIS AGREEMENT IS MADE FREELY AND IS

ALLOWABLE UNDER THE TERMS OF MEDICARE'S CURRENT REGULATIONS. MEDICARE DOES COVER CONCUSSION TESTING AND TREATMENT.

****Patient/Guardian Signature: ______________________________________________ Date: ____________________

**Medical Information Release Form**

**(HIPAA Release Form)**

**Name:** ________________________________________________ **Date of Birth**: _______/________/_____________

Release of Information

[ ] I authorize the release of information, including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse ________________________________________________

[ ] Child(ren) _____________________________________________

[ ] Other _________________________________________________

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my Home ________________________________ [ ] my work _________________________________

and/or [ ] my cell __________________________________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] ______________________________________________

The best time to reach me is (day) _________________________________ between (time) ______________________

Signature: **X** _______________________________________________ Date: _________________________

Witness: ______________________________________________________ Date: _________________________

# AUTO ACCIDENT INFORMATION FORM

**PATIENT NAME: ________________________________________ BIRTHDATE: ___________**

**PLEASE PROVIDE THE FOLLOWING INFORMATION:**

**AUTO INSURANCE COMPANY:___________________________________________________**

**ADDRESS:**

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

**PHONE NUMBER: _______________________________________________________________**

**NAME OF ADJUSTER: ____________________________________________________________**

**NAME OF POLICYHOLDER: ________________________________________________________**

**CLAIM #: ______________________________________________________________________**

**DATE OF ACCIDENT: ____________________________________________________________**

**IF THERE WAS A SECOND AUTO INVOLVED IN THIS ACCIDENT AND YOU HAVE THEIR INSURANCE INFORMATION, YOU MAY PROVIDE IT BELOW:**

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

**You agree to pay a $25 office visit fee at the time of each visit. This fee will be refunded to you when your NO- Fault Motor Vehicle Insurance or Medical Insurance pays the outstanding balance in full.**

**SIGNATURE: X _________________________________ TODAY'S DATE: _________________**

# WORKMAN'S COMPENSATION – ON THE JOB ACCIDENT

**PATIENT NAME:** ______________________________________ **BIRTHDATE:** ________________

**PLEASE PROVIDE THE FOLLOWING INFORMATION:**

**EMPLOYER:** ______________________________________________________________________

**ADDRESS:** ________________________________________________________________________

_________________________________________________________________________________

**PHONE #:** _______________________________________________________________________

**SUPERVISOR:** ____________________________________________________________________

**DATE OF ACCIDENT:** ______________________________________________________________

**WAS THIS ACCIDENT REPORTED (CIRCLE ONE): YES - NO**

**IF YES, TO WHOM?** ________________________________________________________________

**IS THIS AN INSURANCE CLAIM? YES - NO**

**IF YES, PLEASE GIVE THE NAME AND ADDRESS OF THE INUSRANCE COMPANY. IF NOT, PLEASE GIVE THE NAME AND ADDRESS OF THE PERSON RESPONSIBLE FOR PAYING THE CLAIM:**

**NAME:** ___________________________________________________________________________

**ADDRESS:** ________________________________________________________________________

_________________________________________________________________________________

**PHONE #:** ________________________________________________________________________

**CLAIM #:** ________________________________________________________________________

**ADJUSTER'S NAME:** _______________________________________________________________

**You agree to pay a $25 office visit fee at the time of each visit, which will be refunded to you when your Worker's Compensation Insurance, Medical Insurance or Employer pays the outstanding balance in full.**

**SIGNATURE: X** _________________________________ **TODAY'S DATE:** __________________