

**MAC CLINIC – HWMC: PATIENT INFORMATION AND CONSENT FORM**

Date: \_\_\_/\_\_\_/\_\_\_\_\_ Acct. # \_\_\_\_\_  
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 PRIVACY NOTICE**

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 (HIPPA).

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

Relationship to the Patient

\_\_\_\_\_ 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 \_\_\_\_\_

X \_\_\_\_\_ X \_\_\_\_\_

Signature of Policyholder of Designee (REQUIRED)

Signature of Claimant, if other than Policyholder (REQUIRED)



**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:  Home \_\_\_\_\_  Mobile \_\_\_\_\_  my work \_\_\_\_\_

Please Text \_\_\_\_\_  Please Email \_\_\_\_\_

Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_

