



PATIENT INFORMATION (Please Print)					
PATIENT NAME LAST		FIRST		MI	SOCIAL SECURITY NUMBER
ADDRESS			CITY	STATE	ZIP CODE HOME PHONE ()
SEX <input type="checkbox"/> M <input type="checkbox"/> F	AGE	DATE OF BIRTH	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		REFERRED BY
PATIENT EMPLOYED BY (OR SCHOOL)				OCCUPATION	
WORK ADDRESS			CITY	STATE	ZIP CODE BUSINESS PHONE ()
WHAT OTHER FAMILY MEMBERS ARE SEEN HERE?					

INSURANCE	PRIMARY	Responsible Party (if Different from above)		DATE OF BIRTH	RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian	
	ADDRESS		CITY	STATE	ZIP CODE	SOCIAL SECURITY NUMBER
	INSURANCE COMPANY	I.D. NUMBER: GROUP NUMBER:	EFFECTIVE DATE OF INSURANCE:		MEDICARE NUMBER	MEDICAID NUMBER
	EMPLOYER	COMPANY ADDRESS		CITY	STATE	ZIP CODE PHONE ()
	SECONDARY (if Applicable)	Responsible Party (if Different from above)		DATE OF BIRTH	RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian	
	ADDRESS		CITY	STATE	ZIP CODE	SOCIAL SECURITY NUMBER
	INSURANCE COMPANY	I.D. NUMBER: GROUP NUMBER:	EFFECTIVE DATE OF INSURANCE:		MEDICARE NUMBER	MEDICAID NUMBER
	EMPLOYER	COMPANY ADDRESS		CITY	STATE	ZIP CODE SOCIAL SECURITY NUMBER

I PREFER TO BE CONTACTED: By Phone By Mail Other (as discussed with physician)

If you prefer to be contacted by phone, please list numbers below:

Days: () Evenings: () Other(Cell) ()

May a message be left on your answering machine or voicemail? Yes NO

Emergency Contact/Authorization for Release of Patient-Identifiable Health Information *

I authorize my health information to be discussed with or disclosed to the following named individuals and I agree that a photocopy of this authorization shall be as valid as the original.

Name: _____ Relationship to you: _____ Phone: () _____

Name: _____ Relationship to you: _____ Phone: () _____

Name: _____ Relationship to you: _____ Phone: () _____

The following information is to be disclosed:

My healthcare information (if any of the following apply please check):

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Physician Notes |
| <input type="checkbox"/> | <input type="checkbox"/> | lab results |
| <input type="checkbox"/> | <input type="checkbox"/> | x-ray reports |
| <input type="checkbox"/> | <input type="checkbox"/> | consultation reports / Physical Therapy Reports |

Healthcare information related to mental health, alcohol or drug abuse or developmental disability.

-
- Other _____

Any restrictions not noted on this form? (please explain): _____

Unless otherwise revoked, this authorization will expire on the following date, event or condition: (If I do not specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed). DATE: _____ / _____ / _____

X _____ DATE: _____ / _____ / _____
PATIENT OR RESPONSIBLE PARTY

Office policy is to release results of HIV or sexually transmitted disease testing to the patient only.

FINANCIAL RESPONSIBILITY

I understand that my health care insurance carrier or payor of my health benefits may pay less than the actual bill for services. I understand that I am financially responsible for payment in full of all accounts. By signing this statement, I assign to the Commonwealth Medical Health Care provider, any medical/surgical, x-ray, lab or physical therapy benefits that I am entitled to under terms of my health care coverage and agree to be responsible for services not paid, in whole or in part, by my health care payor.

X _____ DATE: _____ / _____ / _____
PATIENT OR RESPONSIBLE PARTY

HIPPA Law provides that upon submission of a request, patients may have access to their own records and may also authorize access by others. Copies of all health care records will be provided at a reasonable cost.



COMMONWEALTH MEDICAL GROUP

RIGHT TO REVOKE AUTHORIZATION

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must provide the revocation in writing to Commonwealth Medical Group. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when law provides my insurer with the right to contest a claim under policy.

RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION

I understand that if I agree to sign this authorization, which I am not required to do, I will receive a copy of this signed authorization.

RIGHT TO INSPECT OR COPY THE INFORMATION TO BE USED OR DISCLOSED

I understand that I have the right to inspect or copy the information used or disclosed in the authorization. I can contact Commonwealth's Privacy Officer.

PROHIBITION OF CONDITIONS

Commonwealth Medical Group may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits based on the provision that I authorize this disclosure of my protected health information.

REDISCLASURE

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact Commonwealth's privacy officer at the office information listed.

RELEASE

I understand that Commonwealth Medical Group may release medical information necessary to process this claim. In addition this information may be given to other providers of services, intermediaries, medical review boards and/or personal and other organizations including federal agencies.