Commonwealth Medical Physician Group

Patient Information

PLEASE PRINT / PLEASE FILL IN COMPLETELY

PATIENT

PATIENT NAME _____
FIRST *LAST*

SEX ☑ M ☐ F BIRTH DATE _____ MARITAL STATUS _____ SOCIAL SEC. # _____
M/D/YEAR

PATIENT STREET ADDRESS _____
STREET *APT./UNIT* *CITY* *STATE* *ZIP*

HOME TELEPHONE (_____) _____ DAYTIME/CELL TELEPHONE (_____) _____
AREA CODE *PHONE NUMBER* *AREA CODE* *PHONE NUMBER*

EMAIL ADDRESS _____
PLEASE PRINT CLEARLY

EMPLOYED BY _____
ORGANIZATION *CITY* *STATE*

WHO TO NOTIFY IN CASE OF EMERGENCY _____ RELATIONSHIP _____
FIRST *LAST*

DAYTIME TELEPHONE (_____) _____ EVENING TELEPHONE (_____) _____
AREA CODE *PHONE NUMBER* *AREA CODE* *PHONE NUMBER*

ADDRESS _____
STREET *APT./UNIT* *CITY* *STATE* *ZIP*

INSURED/PAYOR

We do expect payment at time of service for all co-pays and deductibles.
Cash, personal check and VISA, MasterCard, American Express and Discover Card are accepted.
Please fill in your health insurance information below and submit insurance card and photo I.D.

Name of Primary Health Insurance Company	Policy Holder/Name of Insured (usually Employee Name)	Member ID Number

Relationship of policy holder to patient ■ Self ☐ Spouse ☐ Other: _____

AGREEMENTS/ACKNOWLEDGEMENTS

I have completed this form fully and accurately, and certify that I am the patient or authorized agent to furnish information requested. I understand that even though I have some type of insurance coverage, I am financially responsible for all services, and when applicable, non-covered services, deductible and co-insurance according to my policy benefits, as well as any collection fees.

I authorize the physician who provides care and treatment to file a claim on my behalf. I further authorize the release of any medical information necessary to process such claim(s). I authorize payment of medical benefits to Commonwealth Medical Physician Group.

The physicians and staff at Commonwealth Medical Physician Group have always protected the confidentiality of personal health information. Today, state and federal laws also attempt to ensure the confidentiality of this sensitive information. The federal HIPAA ruling is designed to protect the privacy of your health information. This "privacy rule" protects health information that is maintained by physicians, hospitals, other health care providers and health plans. This regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to the hospital, fill a prescription, or send a claim to a heath plan, your physician, the hospital or other health care provider will need to consider the privacy rule. All health information including paper records, oral communications, and electronic formats (such as e-mail) and faxes are protected by the privacy rule.

The privacy rule also provides you certain rights, such as the right to have access to your medical records. However, there are exceptions; these rights are not absolute. We are also taking the necessary precautions in our office to safeguard your health information through records control and security measures.

Henceforth, all personal health information will not be disclosed to other parties except for the treatment and care of your health and to process claims to your health plan, without your specific authorization to do so. Your authorization will be needed before records are sent to workers' compensation authorities; auto, life and disability insurance carriers, attorneys and any and all relatives. While this list which requires your authorization to disclose medical records or personal information is general in scope, there may be additional circumstances that require your written approval. Please let us know if you have any questions about our Notice of Privacy Practices.

I have read all the above notices, including the HIPAA policy regarding confidentiality.

_____
TODAY'S DATE SIGNATURE OF PATIENT OR LEGAL GUARDIAN