CLASSEN FAMILY MEDICINE CLINIC

www.classenfamilymedicine.com

PATIENT INFORMATION

LAST NAME	**FIRST NAME**	MIDDLE INITIAL
SOCIAL SECURITY NUMBER	SEX Male ☐ Female ☐	PREFIX/SUFFIX
DATE OF BIRTH *(mm/dd/yy)*	STATUS *(please check one)* ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner	STUDENT *(please check one)* ☐ No ☐ Full Time ☐ Part Time
MAILING ADDRESS	CITY/STATE	ZIP CODE
HOME PHONE *(include area code)*	WORK PHONE	CELL PHONE
RACE *(please check one)* ☐ White ☐ Black/African American ☐ Asian ☐ Hawaiian/Other Pacific Islander ☐ Other Race American ☐ Indian/Alaska Native	ETHNICITY *(please check one)* ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown	PREFERRED LANGUAGE *(please check one)* ☐ English ☐ Spanish ☐ Other: _____
EMPLOYER / JOB TITLE/STATUS	EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER
EMAIL ADDRESS		
PREFERRED METHOD OF CONTACT FOR APPOINTMENT REMINDERS *(please check one)* ☐ Cell Phone ☐ Home Phone		

EMERGENCY CONTACT (Guarantor information section below must be filled if you are not making payment for visits)

LAST NAME	FIRST NAME	MIDDLE INITIAL	RELATION TO YOU:		
SSN *(social security number)* / DATE OF BIRTH *(mm/dd/yy)*	RELATIONSHIP TO PATIENT	SEX	MARITAL STATUS		
MAILING ADDRESS	CITY/STATE	ZIP CODE	CELL PHONE	HOME PHONE	
EMPLOYER	WORK NUMBER	JOB TITLE			

GUARANTOR Complete ONLY if someone other than the patient is responsible for payment:

CONTACT *(may chose more than one)*	LAST NAME	FIRST NAME	MIDDLE INITIAL	
SSN *(social security number)* / DATE OF BIRTH *(mm/dd/yy)*	RELATIONSHIP TO PATIENT	SEX	MARITAL STATUS	
MAILING ADDRESS	CITY/STATE	ZIP CODE	HOME PHONE	
EMPLOYER	WORK PHONE	JOB TITLE		

Over

Name:_____ Date of Birth:_____

INSURANCE POLICY INFORMATION

POLICY NUMBER	**GROUP ID**		EFFECTIVE DATE (*if known*)
TYPE *(please check only one)* ☐ Health ☐ Auto ☐ Worker's Comp. ☐ Other	PRIMARY INSURANCE? *(please check one)* ☐ Yes ☐ No	END DATE (*if known)*	CO-PAYMENT AMOUNT Office: $_____ Urgent Care: $_____
NAME OF INSURANCE COMPANY/PLAN	**INSURANCE COMPANY ADDRESS**		PHONE NUMBER
INSURED'S NAME: (*May leave blank if same as Guarantor/Patient*)	DATE OF BIRTH *(mm/dd/yy)*		HOME PHONE
INSURED'S MAILING ADDRESS	PRIMARY CARE PHYSICIAN (PCP) &/OR REFERRING PHYSICIAN		

SECONDARY INSURANCE INFORMATION (if applicable)

POLICY NUMBER	GROUP ID		EFFECTIVE DATE (*if known*)
TYPE *(please check only one)* ☐ Health ☐ Auto ☐ Worker's Comp. ☐ Other	PRIMARY INSURANCE? *(please check one)* ☐ Yes ☐ No	END DATE (*if known)*	COPAYMENT AMOUNT Office: $_____ Urgent Care: $_____
NAME OF INSURANCE COMPANY/PLAN	INSURANCE COMPANY ADDRESS		PHONE NUMBER
INSURED'S NAME (*May leave blank if same as Guarantor/Patient*)	DATE OF BIRTH *(mm/dd/yy)*		HOME PHONE

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to Classen Family Medicine, LLC, or any of its affiliates or agents, lenders, or any third party servicer acting for Classen Family Medicine, LLC or any of its affiliates. I also authorize Classen Family Medicine to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

_____ _____
Print Name Date

_____
Signature

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

1. If any CFM health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test.

2. If you should be directly exposed to blood or body fluids of a CFM health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

   I understand that this consent will remain in effect as long as my dependent or I receive care from Classen Family Medicine or until I withdraw it.

_____ _____
Signature of Patient, Parent/Legal Guardian Date

_____
Relationship (if signature is not of Patient)
Signature of Person Obtaining Consent

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Release on Information

I give permission to Classen Family Medicine to discuss my medical condition(s), my treatment, and information regarding my appointments with the following individuals:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Consent to Treat

I hereby authorize Classen Family Medicine, LLC and any of its physicians and/or staff to treat my medical condition(s). The risks, benefits and alternatives will be explained at the time of service. I have the right to question and/or refuse treatment.

_____ _____

Patient Signature Date

Consent to Disclose Health Care Information

It is important for you to know how your rights concerning your records and how your Personal Health Information (PHI) is used in our office. Before we begin any health care operations, we must require you read and sign this consent form stating you understand and agree with how your records will be used.

1. I understand and agree to allow Classen Family Medicine, LLC to use my Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care,
2. Classen Family Medicine, LLC has a document called the "Notice of Privacy Practices" that contains more information about policies and practices used to protect our patients' privacy. I understand that I have the right to read the "Notice of Privacy Practices" before signing this agreement. The notice is posted in the office of Classen Family Medicine, LLC. A written copy will be provided upon request. Classen Family Medicine, LLC may update the "Notice of Privacy Practices" at any time. A copy of the most recent update is available upon request.
3. Under the terms of this consent, I can ask Classen Family Medicine, LLC to restrict how my personal health information is used or disclosed to carry out treatment, payment or health care operations.
4. I understand that Classen Family Medicine, LLC does not have to agree to my request. If Classen Family Medicine, LLC does agree to my request, I understand that agreed limits would be followed.
5. I understand that I have the right to cancel this consent in writing to the Privacy Officer of Classen Family Medicine, LLC. If I do cancel this consent, I understand that Classen Family Medicine, LLC may have used or disclosed information about me and canceling this consent would not apply to information already used or disclosed.
6. I understand that if I cancel this consent, Classen Family Medicine, LLC does not have to provide further healthcare services to me.
7. I grant Classen Family Medicine, LLC permission to view my prescription history from external sources.

I have read and understand how my Patient Health Information (PHI) will be used and I agree to these policies and procedures.

_____ _____

Patient Signature Date

__ _____

Printed Name