PATIENT INFORMATION Physician Dr. Curtis____ Dr. Scurlock_____ Dr. Link_____Dr. Rivera______

Last Name __________________________ First Name ____________________________ Middle Initial _______

Address____City____________________State_____Zip________

Date of Birth___________________ SS#________________________

Primary Phone # ______________________________ Secondary Phone # _________________________________

Employer____ Employer Phone #___________________

Sex: M______ F _____ Race________ Ethnicity ________

Pharmacy Name ____ Phone # ______________________________

Street ____City ____________________________________

RESPONSIBLE PARTY (IF PATIENT IS A CHILD)

The address on the account must be the address where the child resides. Since our system only allows one address, it is the responsibility of the residing parent/guardian to ensure that financial obligations are met.

Last Name __________________________ First Name ____________________________ Middle Initial _______

Email Address _____________________Date of Birth___________________ SS#________________________

Cell Phone # ____________________________________ Home # _______________________________________

Employer____ Employer Phone #___________________

Sex: M______ F _____ Race______________ Ethnicity ________________

Patient Name ___________________________ Date of Birth______________

FINANCIAL RESPONSIBILITY

_____As a courtesy we bill most major insurance companies. Your insurance coverage is a contract between you and your insurance carrier, however, we will assist you to maximize your insurance benefits.

_____Copayments are due at the time of service. You may be asked to pay a portion of your office visit upon check in when a deductible applies.

_____You will be responsible for any portion of your insurance claim that is denied or not paid by your insurance carrier. The Dr. suggests testing and procedures based on the patients best interest not based on your insurance coverage or benefits.

_____Patients without insurance coverage will be asked to pay $50 upon check in as a down payment.

_____An estimate for lab tests may be provided upon request.

_____Returned checks will incur a $25 service Fee.

_____A minimum of $50 per month payment plan can be arranged with the billing dept.

_____Delinquent accounts will be placed with a collection agency with a 30% collection fee.

_____The billing department is available to discuss any specific financial concerns that you may have.

_____I understand my financial obligation.

_____________________________________ ______________________________

Signature Relationship to Patient (if other than patient)

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent

_________________________________ ________________________

Signature Date