HILLCROFT MEDICAL HMC CLINIC ASSOCIATION

HOUSTON | SUGARLAND

PATIENT REGISTRATION - IF OTHER THAN RESPONSIBLE PARTY

PLEASE PRINT

PATIENT NAME ☐ MR . ☐ MS. ☐ MRS. ☐ MISS	FIRST	M.I.	LAST	DATE OF BIRTH (MM/DD/YY)
MAILING ADDRESS	STREET, P.O. BOX, APT		CELL #	MARITAL STATUS
CITY	STATE	ZIP	HOME #	ASSIGNED SEX AT BIRTH ☐ M ☐ F
EMPLOYER	EMAIL ADDRESS			SSN
RACE	ETHNICITY	HISPANIC? YES ☐ NO ☐	PREFERRED LANGUAGE	

PERSON RESPONSIBLE FOR PAYMENT (GUARANTOR)

PLEASE PRINT

YOUR NAME ☐ MR. ☐ MS. ☐ MRS. ☐ MISS	FIRST	M.I.	LAST	DATE OF BIRTH (MM/DD/YY)
MAILING ADDRESS	STREET, P.O. BOX, APT		CELL #	MARITAL STATUS
CITY	STATE	ZIP	HOME #	ASSIGNED SEX AT BIRTH ☐ M ☐ F
EMPLOYER			WORK #	SSN
EMAIL ADDRESS			DRIVERS LICENSE #	STATE

IN CASE OF EMERGENCY, PLEASE CONTACT NEAREST RELATIVE OR:

NAME ☐ MR. ☐ MS. ☐ MRS. ☐ MISS	FIRST	M.I.	LAST	RELATIONSHIP	DAYTIME PHONE #
MAILING ADDRESS	STREET, P.O. BOX, APT		CITY	STATE	ZIP

REFFERRED BY:

☐ DOCTOR_____ ☐ FAMILY/FRIEND_____

RELEASE OF RECORDS & FINANCIAL RESPONSIBILITY STATEMENT

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION OBTAINED AND DOCUMENTED BY HILLCROFT MEDICAL CLINIC DURING THE COURSE OF TREATMENT TO MY INSURANCE CARRIER.

PATIENT SIGNATURE X_____ **DATE** _____

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO HILLCROFT MEDICAL CLINIC. I REALIZE THAT I AM RESPONSIBLE FOR PAYING THE CO-PAYS, DEDUCTIBLE, CO-INSURANCE AND NON-COVERED SERVICES AS DETERMINED BY MY INSURANCE CARRIER. FURTHERMORE, I HEREBY VERIFY I HAVE NO OTHER INSURANCE COVERAGE, PRIMARY OR SECONDARY, OTHER THAN THE CARRIERS LISTED BELOW.

PATIENT SIGNATURE X_____ **DATE** _____

PRIMARY: CARRIER			POLICY HOLDER NAME	POLICY HOLDER SSN
TYPE OF INSURANCE ☐ HMO ☐ PPO ☐ Medicare ☐ MediCaid ☐ Workers Comp ☐ Other			MEMBER ID #	GROUP #
CLAIM ADDRESS (on back of card)	PO BOX #	STATE ZIP	PROVIDER SERVICE PHONE#	
SECONDARY: CARRIER			POLICY HOLDER NAME	POLICY HOLDER SSN
TYPE OF INSURANCE ☐ HMO ☐ PPO ☐ Medicare ☐ MediCaid ☐ Workers Comp ☐ Other			MEMBER ID #	GROUP #
CLAIM ADDRESS (on back of card)	PO BOX #	STATE ZIP	PROVIDER SERVICE PHONE#	

HMC

HOUSTON | SUGARLAND

Hillcroft Medical Clinic Association

Patient Consent and Acknowledgment of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Hillcroft Medical Clinic Association creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I have been provided with a notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any-revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes or treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes, of treatment, payment or health care operations be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

_____ _____

PATIENT'S NAME PRINTED TODAY'S DATE

_____ _____

PATIENT'S SIGNATURE (OR GUARDIAN, IF MINOR) SOCIAL SECURITY # (FOR IDENITIFICATION PURPOSES ONLY)

_____ _____

WITNESS (Optional) TODAY'S DATE

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION AND INFORMATION RELEASE

_____ _____

PATIENT'S FULL NAME MEDICARE I.D. NUMBER

I request that payment of authorized Medicare benefits be made either to me or on my behalf to (name of physician/ supplier) for any services furnished by me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient ls responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

PATIENT'S SIGNATURE DATE