

PLEASE PRINT	FIRST	ATTENT REGISTR	ATION - IF M.I.	OTHER THAN	RESPONSIBLE PARTY		PLEASE PRINT
PATIENT ☐ MR . ☐ MS.	FIKST		IVI.I.		LAST		DATE OF BIRTH (MM/DD/YY)
NAME MRS. MISS							
MAILING STREET, P.O. BOX,	APT			<u> </u>	CELL#		MARITAL STATUS
ADDRESS							
CITY	5	TATE	ZIP		HOME #		ASSIGNED SEX AT BIRTH
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YOUR MR. MS.	TINST		IVI.I.		LAST		DATE OF BIRTH (MM/DD/YY)
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☐ MRS.☐ MISS	TIKST	IVI.I.	LASI		RELATIONSTIII	DAIII	WILL I FIGURE #
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## 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 anyrevised 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 supplier) for any services furnished by me by that physician/supplier) for any services furnished by me by that physician/supplied by the to release to the Health Care Financing Administration these benefits or the benefits payable to related services.	plier. I authorize any holder of medical information
I understand my signature requests that payment be made and pay the claim. If other health insurance is indicated in Item 9 of approved claim forms or electronically submitted claims, my signisurer or agency shown. In Medicare assigned cases, the physic determination of the Medicare carrier as the full charge, and the coinsurance, and non-covered services. Coinsurance and the dethe Medicare carrier.	the HCFA-1500 claim form or elsewhere on other mature authorizes releasing of the information to the cian or supplier agrees to accept the charge e patient is responsible only for the deductible,
PATIENT'S SIGNATURE	DATE