Release of Information Authorization & Assignment of Benefits

I hereby authorize the release of medical information to insurance carriers concerning my illness and treatment, and I hereby assign to Physicians East, P.A., if they so elect, all payment for medical services rendered to me or to my dependents. I understand that I am responsible for any amount of payment not covered by insurance.

Initials _____

Would you like to give authorization to Physicians East, P.A. to release your protected health and/or billing information to a person of your choice? If so, please check the appropriate box below and the proper authorization form will be presented to you.

☐ YES ☐ NO

Consent to Treat

I authorize medical treatment as deemed necessary and appropriate by the Providers of Physicians East, P.A. and their employees participating in my care. I will provide any necessary information related to my healthcare needs that may affect the treatment I may receive, including but not limited to; past medical history, past and current medications, and current medical issues. I understand that if I do not provide all necessary information pertaining to my current health, that I will not hold the providers or other employees of Physicians East, P.A. liable for any adverse reactions.

Initials _____

HIPAA Notice of Privacy Practices Acknowledgement

I have received, read and understand your Notice of Privacy Practices. I understand that this information will be used to carry out treatment, payment, and normal healthcare operations of the Practice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Initials _____

Agreement of Financial Responsibility for Routine, Preventative, and Non-Covered Services

Routine and Preventative services are not covered by most insurance plans. Your insurance plan may not cover your visit today if you do not have a medical complaint or significant problem/abnormality. In the event that services provided are denied as routine, preventative pre-existing, or non-covered, you will be responsible for the balance.

Initials _____

Medicare Lifetime Signature on File (for Medicare patients only)

I request that payment of authorized Medicare benefits be made on my behalf directly to this practice for any services provided to me by the physician. I authorize the release of any medical or other information necessary for processing claims to the center for Medicare and Medicaid Services.

Initials _____

By signing below, I acknowledge that this form and all policies have been read in full, explained as necessary, and that all information that I provided is accurate.

_____

Patient Name (Please Print)

_____ _____

Signature of Patient (or Legal Guardian) **Date**

PHYSICIANS EAST, P.A.

PROVIDING COMPREHENSIVE HEALTH CARE TO EASTERN NORTH CAROLINA

For Staff Use Only

MRN: _____ Date: _____

Subscriber Information: _____

_____

Patient Demographic Form

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____/____/____

Street Address: _____ City: _____

State: _____ ZIP Code: _____

Home Number: (_____) _____-_____ Cell Phone: (_____) _____-_____

Day Number: (_____) _____-_____ Employer: _____

Contact Preference (Please Circle): Home Cell Work Text

Emergency Contact: _____ Number: (_____) _____-_____

Relationship to Patient: _____

To communicate with us electronically in order to request appointments, medication refills, medical records, please provide your email address to be registered with our portal.

Email Address: _____

Do you currently have a Primary Care Provider (PCP)? Yes / No

If yes, please provide your PCP's name. _____

The federal government has asked us to report race, ethnicity, and language. It is your choice to answer. If you wish please circle the choice you identify with.

Race: American Indian/Alaskan Native Asian Black Native Hawaiian/Pacific Islander White

Ethnicity: Not Hispanic/Latino Hispanic/Latino

Language (If other than English): _____

Contact by Text

I consent to Physicians East, P.A. contacting me by text message for the purpose of health promotion and appointment reminders. I understand these messages may be generated by an automated dialing system and I am responsible for any charges by my wireless carrier. I understand risks are associated with using text messages. I understand texts are transmitted over a public network onto a personal telephone and as such may not be secure. I understand Physicians East, P.A. will not transmit any personal health information. I consent to participating in text notifications.

Initials _____

Rev. Date 9/29/2016 PE-255