McLeod
Physician Associates

Primary Care Physician
Referring Physician
Date mm/dd/yy

Patient Information

Patient Last Name	Patient First Name	Middle Initial
Mailing Address	City	State/Zip Code
Home Telephone # (with area code)	Cell #	Date of Birth
Social Security #	Gender	Marital Status
	___Male ___Female ___Transgender	___Married ___Single
Email Address		___Divorced ___Separated
		___Widowed ___Partner
Race: __Asian __Hawaiian __American Indian __ White __Black or African American __Hispanic __Other		Ethnicity
Language: __English __Indian (Includes Hindi and Timil) __Spanish __Russian __Other		__Hispanic or Latino __Non Hispanic or Latino

Patient Employer Information

_____N/A--Not currently employed

Employer Name	Telephone # (including area code)
Employer Address	

Guarantor Information

Person Responsible for Payment of Services After Insurance - If Patient, Check and Initial Here _____

Guarantor Last Name	Guarantor First Name	Middle Initial
Mailing Address	City	State/Zip Code
Social Security #	Date of Birth	Gender
		___Male ___Female ___Transgender
Home Telephone #	Cell #	Relationship to Patient
		___Parent/Guardian ___Spouse

Primary Insurance Information

_____No Insurance/Self Pay

Primary Insurance Name	Group ID#	CoPay	Member ID#
Subscriber Last Name	Subscriber First Name		Middle Initial
Mailing Address	City		State/Zip Code
Social Security #	Date of Birth		Gender
			___Male ___Female ___Transgender
Home Telephone #	Cell #		Relationship to Patient
			___Parent/Guardian ___Spouse

Secondary Insurance Information

_____N/A

Secondary Insurance Name	Group ID#	CoPay	Member ID#
Subscriber Last Name	Subscriber First Name		Middle Initial
Mailing Address	City		State/Zip Code
Social Security #	Date of Birth		Gender
			___Male ___Female ___Transgender
Home Telephone #	Cell #		Relationship to Patient
			___Parent/Guardian ___Spouse

Pharmacy Name:		**Pharmacy Address:**	

Which of the following helped you decide to see this physician/practice? (check all that apply, if possible)

___Physician Referral/ER Visit ___Friend/Family ___Ad in Newspaper/Magazine ___ Mail/Postcard ___Radio/TV Advertising

___Internet Search/Social Media Advertising ___Physician Speaking Event/Health Fair

MCLEOD PHYSICIAN ASSOCIATES

PATIENT CONSENT FOR TREATMENT, SERVICES AND PAYMENT

Consent for Treatment and Services: I/we hereby give my consent for treatment and related services considered necessary by McLeod Physician Associates II ("MPA") for the patient whose name appears below who is seeking or is under the care of the applicable MPA physician, his/her associates, partners, assistants, employees or designees. I/we hereby understand that such treatment, may include, but is not limited to, necessary examination and/or assessment, laboratory, diagnostic and/or medical care and procedures; prescribed medical information, if available; and/or recordings and/or filming for internal purposes, which the MPA physician, his associates, partners, assistants, or designees may deem necessary or advisable. I/we understand that if medical treatment of an urgent nature is necessary for the patient named below, MPA physicians, his/her associates, partners, assistants, employees, providers, or designees will perform such laboratory, diagnostic and/or medical care and procedures.

Assignment of Insurance Benefits and Third Party Claims: I/we hereby authorize payment directly to MPA of medical benefits otherwise payable to me, including major medical insurance benefits, PIP benefits, sick benefits, or injury benefits due because of any insurance policy and the proceeds of all claims resulting from the liability of the third party payable by any person, employer or insurance company to or for the patient unless I/we pay the account in full upon the receipt of services. I/we also authorize payment of surgical, or medical, including major medical benefits, directly to MPA physicians, but not to exceed charges for these services. I/we also authorize payment of medical benefits otherwise payable to me for professional services performed by any designated service provider or physician on the active medical staff of McLeod Health and/or MPA. I/we understand that I/we am financially responsible to MPA physicians and all providers of service for charges incurred, whether or not covered by this assignment. I/we understand that should the account be referred to an attorney for collection, I/we shall pay all reasonable attorney's fees and collection expenses. All delinquent accounts may bear interest at the legal rate. I/we further agree that in the event medical benefits exceed charges for services in connection with this episode of care, that any such excess amount be first applied to the payment of any other indebtedness due by me for treatment and services rendered or any for amount for which I/we am responsible on account of other episodes of care or services received from MPA, and the balance, if any remains, to be paid to me. I/we further authorize refund of overpaid insurance benefits in accordance with my policy conditions where my coverage is subject to the coordination of benefits clause. I/we further agree that MPA is authorized to act in my behalf in the endorsement of benefit checks made payable to me and/or MPA. If I/we am a participant /beneficiary of an employee welfare plan governed by the Employee Retirement Income Security Act of 1974 (ERISA) , 29 U.S.C. § 1001 et seq, I/we designate MPA as my authorized representative and grant to MPA to act on my behalf in pursuing and appealing a benefit determination under the plan. Such authority shall include the right to request and receive a copy of the plan description and/or summary plan description.

Medicare-Medicaid's Patient's Certification: Payment Request: I/we assign payment for the unpaid charges for certain physician services furnished by specialists and physicians for whom MPA is authorized to bill. I/we understand that I/we am responsible for any health insurance deductibles and co-insurance. I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I/we request that payment of authorized benefits be made on my behalf.

Payment Guarantee: I/we hereby jointly and severely agree to pay all charges for services received by the patient named below during this "episode of care" and/or subsequent visits.

Follow-Up/New Episodes of Care: I/we understand that the patient named below may come in for subsequent episodes of care following his/her initial visit to MPA. I/we understand that the patient named below may receive subsequent care and/or treatment related to such episodes of care. I hereby acknowledge that I/he/she will not be required to complete a subsequent registration form containing all of the information stated within this Patient Consent for Treatment, Services, and Payment but agree to be bound by the terms and conditions herein.

I/we have read the above Patient Consent for Treatment, Services and Payment, have had the opportunity to ask questions for clarification and understand the same and certify that no guarantee or assurance has been made as to the results that may be obtained as related to such treatment and services.

By signing below you are confirming your acknowledgement of the use of an electronic medical record (EMR) in order to access and share protected health information by MPA and the MPA Network and that you are in agreement with such sharing, exchange, and use of your protected health information in order to provide medical care and carry out services related to your treatment. I further confirm and understand that McLeod Health and MPA has an electronic health information exchange (HIE) to send my health information to myself or to my physicians.

_____	_____	_____
Patient or (Authorized Representative)	Date	Witness

_____
Financially Responsible Party

_____	_____	_____
Patient's Name	Account Number	Treatment Date

Acknowledgement of the Notice of Privacy Practices

I/we hereby acknowledge that I/we have been offered a paper copy of the McLeod Health Notice of Privacy Practices, which sets forth the manner in which the protected health information of the patient named below may be used or disclosed by MPA and/or McLeod Health and outlines applicable rights with respect to such information. I/we also acknowledge that I/we have been allowed to ask questions as related to the Notice of Privacy Practices. If I/we am not the patient, I/we represent that I/we am authorized by law to act for and on the patient's behalf as indicated below.

_____	_____
Signature of Patient or Authorized Representative	Date

Designation of Care Givers for Communication of Protected Health Information

For the following patient: Today's Date: ____/____/____

Patient Name:_____ Date of Birth: ____/____/____

Account #; _____ Chart #: _____

At my request, I authorize the person(s) listed below to inquire about my personal health and/or billing information on my behalf. In case of a minor child, this Person(s) may inquire about the child's personal health and/or billing information and, if necessary, bring the child to appointments on my behalf.

Name	Relationship	Date of Birth	Phone Number(s)
Name	Relationship	Date of Birth	Phone Number(s)
Name	Relationship	Date of Birth	Phone Number(s)

OR

_____(init) I do not want any of my personal or financial information to be given to anyone other than myself and my physicians.

At my request, I authorize McLeod Physician Associates II to communicate my protected health information to me via the following methods:

- ☐ Leave detailed message at this number (Phone: _____)
- ☐ Leave message with call-back number only (Phone: _____)
- ☐ Fax detailed medical information (Fax: _____)
- ☐ E-mail detailed medical information (E-mail: _____)
- ☐ Mail medical information to this address (Address:_____)

Who would you like us to notify in case of an emergency?

Name	Relationship	Date of Birth	Phone Number(s)

I understand that my health care providers will use judgment in determining the minimum amount of information that must be shared in order to care for me.

McLeod Physician Associates II will make a diligent "good faith" effort to determine the identity of the requestor before release of my personal health and/or billing information by verifying the address, date of birth and phone number for the authorized representatives I have designated. McLeod Physician Associates II is not liable for any misuse of my personal health or billing information by the representative(s) authorized (listed) above. I understand this authorization will remain in effect unless otherwise notified and/or revoked.

_____ _____ _____

Authorized Patient or Guarantor Signature Print Name Date

I understand that I may cancel this authorization at any time by signing this notice below. However, if I cancel this authorization, I also understand that the cancellation will **not** affect any action McLeod Physician Associates II took in reliance on this authorization before receipt of written notice of cancellation.

Signature Authorizing Cancellation: _____

Date Authorization Cancelled: ____/____/____