

Acct#: _____

Medical Care, PLLC medical records and patient information confidentiality policy

In compliance of state and federal regulations, Medical Care will not release an individual's medical records or information without the patient's written authorization. The patient may restrict or revoke the authorization to release medical information at any time. We ask that you instruct us on what medical information can be shared, with whom, and by what means of communication.

How Can Medical Care contact you?

Please answer all the following:

Initial: _____

May we leave a message on your answering machine for:

The purpose of appointments/scheduling/referrals?

yes _____ no _____

The purpose of medical test results?

yes _____ no _____

Fax your medical information/results/appointments?

yes _____ no _____

Fax # _____

E-mail you medical information/recommendations?

yes _____ no _____

Text your mobile phone with appointment reminders?

yes _____ no _____

Service Provider _____

If Medical Care cannot reach you, is there another person with whom we can discuss your medical information? Please list relationship/contact phone numbers:

Name: _____ Relationship: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____

If patient is a minor. I authorize the following people to bring my child or dependant to Medical Care for treatment:

Name: _____ Relationship: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____

ALL PATIENTS: CASH PAY, TENNCARE, MEDICARE, AND PRIVATE INSURANCE

I agree to be financially responsible for any service I receive and to pay any charges necessary to collect, including but not limited to collection fees, attorney fees and court costs.

Signed : _____ Printed Patient Name : _____

Date : _____ Patient's Date of Birth: _____

INSURANCE

I authorize the release of any medical information necessary to process claims. I authorize payment of medical benefits to Medical Care, LLC or the named provider for professional services rendered. I agree to be responsible for charges not paid by my insurance (co-pay, deductible, not covered services, etc.) We cannot bill your insurance company unless you give us your correct insurance information at the time of service. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. Please be aware that some, and perhaps all, of the services provided to you may be non-covered services and not considered reasonable and necessary under the Medicare program and/or medical insurance.