

MANNING REGIONAL HEALTHCARE CLINIC

ADULT PATIENT:

Date:_____ Patient Name_____
 First Middle Initial Last

Date of Birth_____ Telephone #_____ Cell #_____ Sex: M F

Social Security #_____ Marital Status: S M W D

Street Address_____

City_____ State_____ Zip_____

Do you have a Living Will or Advance Directives? ___Yes ___No If you would like information about a Living Will or Advance Directives please ask the receptionist or your healthcare provider.

EMPLOYMENT:

Employer:_____ Position_____

Address:_____ Phone #_____

SPOUSE' S NAME_____ Birthdate_____

Social Security #_____ Telephone #_____ Cell phone #_____

Employer_____ Employer Address_____ Phone #_____

EMERGENCY CONTACT:

Name_____ Phone #_____

PAYMENT FOR SERVICES:

Do you have insurance? Yes_____ No_____

► ***If no insurance coverage, which form of payment will be used?***

Cash___ Check___ Credit Card___ ***Payment in full is expected at the time of service.***

Person financially responsible for payment of this account_____

INSURANCE INFORMATION:

We will be happy to file your insurance for you today. Please provide accurate insurance information. You are responsible to pay your co-pay and/or deductible at each visit. Because your insurance coverage is an agreement between you and your insurance company, all medical expenses are ultimately your responsibility.

(1) Insurance Company Name:_____

Subscriber_____ Birthdate_____ Policy Number_____

(2) Insurance Company Name:_____

Subscriber_____ Birthdate_____ Policy Number_____

DEPENDENT CHILDREN'S NAMES:

BIRTHDATE:

CONSENTS

FOR TREATMENT AND EVALUATION:

I have come to the Manning Regional Healthcare Clinic for evaluation and treatment. I give my consent to the healthcare providers of the Manning Regional Healthcare Clinic to examine and treat me.

X _____
Signature of patient. Date

CONSENT FOR RELEASE OF MEDICAL INFORMATION FOR TREATMENT, PAYMENT, HEALTHCARE OPERATIONS AND ASSIGNMENT OF BENEFITS:

I have been given the opportunity to review the clinic's "Notice of Information Practices" which summarizes the ways my Individually Identifiable Health Information (IIHI) may be used or disclosed by the Clinic for treatment, payment and healthcare operations and states my rights with respect to my IIHI. By signing this form, I am consenting to the Manning Regional Healthcare Clinic's use and disclosures of my IIHI as outlined in the "Notice of Information Practices."

I give my consent to the Manning Regional Healthcare Clinic staff to call my home or other designated location and leave a message on the answering machine, voice mail, or in person, mail to my home or other designated location, or e-mail my home or other designated location, any items that assist the clinic in carrying out treatment, payment and healthcare operations. This can include, but is not limited to, such things as appointment reminders, insurance or billing concerns, lab results, specialty appointments, and procedure appointments.

By providing us with your wireless/cell phone number, you are hereby granting us, and our agents or independent contractors, your consent to receive calls on your wireless/cell phone number for billing and debt collection purposes.

I authorize the release of any medical information necessary to process all claims from Manning Regional Healthcare Clinic. I also request payment of insurance benefits (including Medicare if applicable) to be made to Manning Regional Healthcare Clinic.

X _____
Signature of Patient or guardian Date

PRINT PATIENT NAME Guardian's relationship (if applicable)