DEKALB HEALTH
MEDICAL GROUP

Patient Name:_____ DOB:_____

Annual HIPAA Notice/Release Info

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that protects your Personal Health Information. As part of this law, we require you to choose one of the following about receiving a copy of the **Notice of Privacy Practices & Patient Rights and Responsibilities:**

I have ◯ Accepted ◯ Declined the Notice of Privacy Practices _____ Patient Initials

I have ◯ Accepted ◯ Declined the Notice of Patient Rights & Responsibilities _____ Patient Initials

I have ◯ Accepted ◯ Declined the Discrimination Process and How to File Grievance _____ Patient Initials

Release of Protected Health Information

While you are under our care, you may want all or part of your medical information to be shared with a family member, friend, and other individuals. We are obligated by federal law to have your permission before we allow a disclosure of this type. Therefore, if you would like to allow other persons besides yourself access to your Personal Health Information, please list them below and sign in the space provided. By signing, I understand that I may revoke this release of the information at any time and WILL notify DeKalb Health Medical Group of any such request. Any revocation made will have no effect on action taken prior to the date of the revocation.

DeKalb Health Medical Group may disclose my Personal Health Information to the following:

1._____ _____ _____
Name | Relationship | Phone Number
☐ Authorize to Release Info ☐ Emergency Contact ☐ Bring in for Appointments

2._____ _____ _____
Name | Relationship | Phone Number
☐ Authorize to Release Info ☐ Emergency Contact ☐ Bring in for Appointments

3._____ _____ _____
Name | Relationship | Phone Number
☐ Authorize to Release Info ☐ Emergency Contact ☐ Bring in for Appointments

4._____ _____ _____
Name | Relationship | Phone Number
☐ Authorize to Release Info ☐ Emergency Contact ☐ Bring in for Appointments

_____ _____
Signature of patient/Authorized Representative **Date**

_____ _____
Signature of DHMG Representative **Date**

Revised December 2016

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Patient Information **Date**_____

Last Name:_____ First Name:_____ Middle Initial:_____

Mailing Address:_____ Apt #_____

City: _____State:_____ Zip:_____

Sex: Male/Female Date of Birth:_____ Marital Status:_____

Social Security No:____-_____-_____ Nickname:_____

Race *(Please circle one):* **Caucasian/White** **African American** **American Indian**
Asian **Alaskan Native** **Native Hawaiian** **Pacific Islander** **Other**

Ethnicity (circle one): **Not Hispanic or Latino** **Hispanic or Latino**

Primary Language in Home (circle one): **English** **Spanish** **Other:**_____

Home Phone:_____ Cell:_____ Work:_____
Preferred Method to contact (***Please choose one***): ☐ Phone ☐ Text ☐ E-mail

Email:_____ Employer:_____
Providing your e-mail address automatically enrolls you in our Patient Portal

Please give the receptionist your: driver's license, insurance card(s), and prescription cards to scan.

Pharmacy Name (*for prescription orders*):_____
Address/Location:_____
Prescription ID Number (*if you have a separate card*):_____ or ☐N/A

Primary Insurance
Insurance Plan Name:_____
Policy Holder:_____ DOB:_____ Sex: **M** or **F**
Address:_____ City:_____ State:_____ Zip:_____
Social Security No:____-_____-_____ Employer:_____
ID/Certification No:_____ Group No:_____
Patient's Relationship to policyholder:_____

Secondary Insurance (*If applicable*)
Insurance Plan Name:_____
Policy Holder:_____ DOB:_____ Sex: **M** or **F**
Address:_____ City:_____ State:_____ Zip:_____
Social Security No:____-_____-_____ Employer:_____
ID/Certification No:_____ Group No:_____
Patient's Relationship to Policyholder:_____

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Authorization to Release Information & Pay Insurance Benefits

Authorization for Treatment & Financial Agreement

I authorize treatment of the person named and authorize information to be given to the insurance companies. I authorize to pay all charges and interest shown by statements, promptly upon presentation thereof, unless credit arrangements are agreed upon. It is agreed that payment will not be delayed or withheld because of any insurance coverage of the pendency of claims thereon, and that all proceeds of the insurance for the services rendered in the practice are assigned to DeKalb Health Medical Group.

I agree in order to service my account, send appointment reminders, or to collect any amounts I owe that DeKalb may also contact me by telephone or text message at any telephone number associated with my account. I authorize DeKalb along with any billing or telemarketing services, collection agencies, attorneys or other agents who may work on their behalf to contact me on my residential and/or cellular device using a pre-recorded or artificial voice, automatic telephone dialing system, an auto-dialer, text messages, computer assisted technology, or any other form of electronic communication.

Signature:_____ Date:_____
(Patient or Guardian for Minors)

For Patients Under the Age of 18 Only

Name of Guardian/Custodial Parent:_____ DOB:_____
Address:_____ City:_____ State:_____ Zip:_____
Phone: Home:_____ Cell:_____ Work:_____

Formulary Benefits Consent

By initialing, we ask your permission to obtain prescription drug benefits and information about other medications prescribed by other providers.

Initials_____ Date_____

Medicare Patients ONLY

I certify that the information given by me in applying for payment under the Title XVIII of Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit copy of this authorization to be used in place of the original, and request that payment of authorized benefits be made on my behalf.

_____ _____
Signature of Patient Printed Name of Patient

_____ _____
Medicare ID Number Date