

Subscriber Information – Primary Insurance:

Primary Insurance Name: _____

Name of Policy Holder: _____

Date of Birth: ____/____/____

Patient's Relationship to Policy Holder: _____

Social Security # _____

Patient's ID # _____

Group # _____

Address: _____

City/ST _____ Zip Code _____

Home Phone: (____) _____

Cell Phone (____) _____

Employer Name: _____

Work Phone (____) _____

Subscriber Information – Secondary Insurance:

Secondary Insurance Name: _____

Name of Policy Holder: _____

Date of Birth: ____/____/____

Patient's Relationship to Policy Holder: _____

Social Security # _____

Patient's ID # _____

Group # _____

Address: _____

City/ST _____ Zip Code _____

Home Phone: (____) _____

Cell Phone (____) _____

Employer Name: _____

Work Phone (____) _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)

With my consent, Select Medicine, P.C., may use and disclose protected health information (PHI) about me to carry out treatment. Please refer to Select Medicine, P.C., Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Select Medicine, P.C., reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Tamisha McPherson, MPA, Privacy Officer.

I HEREBY AUTHORIZE THAT MY INSURANCE BENEFITS BE PAID DIRECTLY TO SELECT MEDICINE, P.C. AND ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY UNPAID BALANCE. PLEASE REMEMBER THAT PAYMENT IS YOUR OBLIGATION REGARDLESS OF INSURANCE OR OTHER THIRD PARTY INVOLVEMENT.

*I hereby authorize my: Medical Information Financial Information

disclosed to _____ Relationship _____

PRINT NAME

SIGNATURE

DATE