

PATIENT INFORMATION FORM

All patient information must be completed in full.

Please present your insurance card(s) to receptionist after completing form.

If you have insurance, we will be glad to help you file for any benefits to which you are entitled. However, it remains the responsibility of the individual patient to settle her/his account promptly. To help us file your insurance claim correctly we must make a photocopy of your insurance card. . All co-pay amounts must be paid at the time of the visit.

Patient Name		
Last	First	Middle
Sex:	Birth Date:	Married - Single -
Social Security #		Email Address:
Address		Apartment #
City	State:	Zip Code
Home Phone:		Cell Phone:
Work Phone:		Occupation:
Place of Employment:		Race:
Ethnicity: Hispanic - Non-Hispanic		Primary Language Spoken:
Patient (Responsible Party) Signature:		Date:

INSURANCE INFORMATION

Primary Insurance Coverage	Insurance Co.	
Insured Name	Birth Date:	
Home Address: (if different from patient)		
City	State	Zip Code
ID#	SS#	Relationship to patient:
Insured Place of Employment		
Business Address		
City	State	Zip Code
Secondary Insurance Coverage	Insurance Co.	
Insured Name	Birth Date	
ID#	SS#	Relationship to patient:
Insured Place of Employment		
Business Address		
City	State	Zip Code

Pharmacy _____ Telephone _____

Address _____

Whom may we thank for referring you to our Clinic? _____

Have you been to a Baptist Medical Clinic – Primary Care in the last three years? _____

In case of emergency who should be notified? _____ Phone: _____

Preferred method to receive appointment reminders: Home Phone Cell Phone Text Message



BAPTIST MEDICAL CLINIC
CONSENT FOR TREATMENT

Authorization for treatment, release of medical information, and assignment of insurance benefits.

AUTHORIZATION TO RELEASE: I hereby authorize the Baptist Medical Clinic or my attending physician, to release or disclose to insurance companies and/or outpatient benefit programs information from my medical record pertaining to my treatment as needed to process insurance claims.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby assign payment directly to the Baptist Medical Clinic benefits wherein specified and otherwise payable to me but not to exceed Baptist Medical Clinic regular charges for medical treatment. I understand I am financially responsible for charges not covered by this authorization.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER/PHYSICIAN: I certify that the information given by me in applying for payment under title XVII of the Social Security Administration or its intermediaries or carriers is the correct information needed for Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services, and authorize such physician or organization to submit claims to Medicare for payment.

MEDICAID PATIENT CERTIFICATION: I certify that the information given by me in applying for payment as a recipient of the Medicaid Title XIX Program is correct and request that payment of authorized benefits be made on my behalf. I authorize any holder of medical or other information about me to make available to the Mississippi Medicaid Commission any requested information concerning medical, insurance, financial records relating to my outpatient visits or hospital treatment. I hereby certify all insurance benefits shall be assigned to the Baptist Medical Clinic or to my attending physician for services rendered.

CONSENT FOR TREATMENT: The undersigned authorizes the physician assigned to furnish medical and surgical treatment by those means he/she considers necessary and proper in the treatment of the patients identified below while a patient of Baptist Medical Clinic. This treatment may require diagnostic procedures including but not limited to laboratory tests, blood drawing for those tests, x-rays and electrocardiogram.

FINANCIAL AGREEMENT: For services rendered to the patient named below, I the undersigned, agree to pay all professional, outpatient and/or hospital visit charges not covered by insurance. I also agree to pay reasonable attorney and/or collection fees necessary for the collection of payment.

VALUABLES: The undersigned hereby releases the Baptist Medical Clinic and/or its staff of employees from any responsibility due to loss or damage of any valuables that the patient may keep in his/her possession or that may be brought to him/her by other persons.

TERM: The term of this Consent for Treatment shall be for a period of one year from the date of this signature below, unless otherwise revoked.

Printed Patient Name Signature Patient/Guardian if minor Date
Printed Patient Name Signature Patient/Guardian if minor Date
Printed Patient Name Signature Patient/Guardian if minor Date