PATIENT INFORMATION FOR MEDICAL RECORDS

PATIENT INFORMATION **PLEASE PRINT** **TODAYS DATE**____/____/____

Name_____ _____ _____ Date of Birth____/____/____ Age_____
Last First M

Address_____ _____ _____ _____
Street City State Zip

Phone (_____)_____ (_____)_____ FAMILY Doctor_____
Home Work

SSN _____ Marital Status M___ S___ W___ D___ Sep__

Employer_____ Address_____

Person to notify in case of emergency_____ Phone (_____)_____

SPOUSE, PARENT, OR GUARDIAN INFORMATION:

Name_____ _____ _____ SSN__ _____ Phone (____)_____
Last First M

Address_____ _____ _____ _____ _____
Street City State Zip

Employer_____ Address_____

1ST INSURANCE COVERAGE

Insurance_____ Policy #_____

Insurance address_____ _____ Effective date_____

Subscriber_____ SSN_____ Date of Birth _____/_____/_____

Relationship to patient_____

2ND INSURANCE COVERAGE

Insurance_____ ____ Policy #_____

Insurance address_____ _____ Effective date_____

Subscriber_____ _____ SSN_____ Date of Birth _____/_____/_____

Relationship to patient_____

3RD INSURANCE COVERAGE

Insurance_____ Policy #_____

Insurance address_____ Effective date_____

Subscriber_____ SSN_____ Date of Birth _____/_____/_____

Relationship to patient_____

PLEASE SIGN AND RETURN TO RECEPTIONIST

I, the undersigned, have insurance coverage with_____
Name of Insurance Carrier

and assign directly to_____ all surgical and/or medical benefits, if
Name of Doctor

any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by Insurance. I hereby, authorize the doctor to release all information necessary to secure the payment of beneifts.

DATE _____/_____/_____ SIGNED_____

PRIVACY QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

_____

_____

2. Please print the telephone number, if any, where you want to receive calls about your appointments, lab and x-ray results, or other health care information.
( ) _____, this number is my: HOME WORK OTHER

3. Can confidential messages (i.e.: appointment & out pt service reminders) be left on your home phone answering machine or voicemail? YES NO

4. Can confidential messages (i.e.: appointment & out pt service reminders) be left with a family member that answers your home telephone? YES NO

If so who? _____

5. If you do not have voicemail, can a confidential message be left at your place of employment? YES NO
If yes, list number _____

PATIENT NAME _____

PATIENT/GUARDIAN SIGNATURE _____

DATE: _____ WITNESS _____

WOMENS ALLIANCE of JACKSON
PRIVACY ACT

GARY FARHAT MD
GARLAND SCOTT MD

I have been given the HIPAA Privacy Statement to read and take with me to keep for reference.

I understand that Womens Alliance of Jackson, P.C. has notified me of their privacy policy.

I understand this document will be in my patient file.

I understand I will be notified of any changes to the Privacy Statement.

PATIENTS NAME _____

SIGNATURE _____

DATE _____

* valid, unless revoked in writing.

WOMEN'S ALLIANCE OF JACKSON, INC.

Gary E. Farhat, M.D., Garland D. Scott, M.D.
Obstetrics and Gynecology

Foote Health Center
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Jackson, Michigan 49201

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Fax (517) 787-1988

To our patients:

Please notify the Medical Assistant of any special instructions that you may have for your **LAB WORK**. As a general rule, most lab work is sent to Foote Hospital. If you or your insurance company require you lab work to be sent to any other location, it is necessary to inform the Medical Assistant **PRIOR** to labs being sent out.

We are not responsible for labs being sent to the wrong location, if not specified at the time of service.

_____

Patient signature Date

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED

For Non-Medicare Patients

I hereby assign to the Provider any and all benefits from any insurance plans or any other protection maintained by the Patient and/or for the Patient's behalf or benefit and authorize and direct such benefits to be paid directly to the Provider for services provided to the Patient by the Provider. I certify that the information given by me to the Provider in applying for payment under Medicare and/or Medicaid programs, Insurance plans, or other protection is correct and complete. I authorize release of all records required to act on this release and assignment.

For Medicare Patients

I request that payment of authorized Medicare benefits be made to me or on my behalf to Gary Farhat, M.D. for any services furnished me by that provider. I authorize any holder of my medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. I certify that the information given by me to the Provider in applying for payment under the Medicare program is correct and complete. I authorize release of all records required to act on this release and assignment. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient Name_____

Witness_____

Date_____