

*****PATIENT INFORMATION FOR MEDICAL RECORDS*****

TODAYS DATE ___/___/___

Last Name _____ First Name _____ MI ___ Date of Birth ___/___/___ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

SSN _____ Marital Status M ___ S ___ W ___ D ___ Sep _____

Employer _____ Address _____

Person to notify in case of emergency _____ Phone _____

Family Dr _____ Pharmacy Name _____

SPOUSE, PARENT, OR GUARDIAN INFORMATION

Last Name _____ First Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Employer _____ Address _____

1ST INSURANCE COVERAGE

Insurance _____ Policy Holder _____ Relationship _____

Policy Holder SSN _____ Policy Holder Date of Birth ___/___/___

Effective Date ___/___/___

2ND INSURANCE COVERAGE

Insurance _____ Policy Holder _____ Relationship _____

Policy Holder SSN _____ Policy Holder Date of Birth ___/___/___

Effective Date ___/___/___

PLEASE SIGN AND RETURN TO RECEPTIONIST

I the undersigned, have insurance coverage with _____ and assign directly to Dr. Garland Scott all surgical and/or medical benefits, if 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 benefits.

DATE ___/___/___ SIGNED _____

**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 Garland Scott, 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 _____

Patient Update

Today's Date _____ Your Name _____

Birth Date _____

Current Medications:

Please list any allergies and the type of reaction that you have:

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.