Patient Authorization and Responsibility Form

Patient Name: _____ Date of Birth: _____

I, the undersigned, hereby acknowledge and agree to the following terms and conditions:

Authorizations/assignment of Benefits:

I hereby authorize and assign payment any benefits due me under the terms of any insurance policy or policies that may cover the procedure performed on me, or my dependent(s) by Emanate Health Medical Group (herein after referred to EHMG) directly at the address designated by EHMG on my claim form submitted to my insurance carrier _____. I agree that payment to EHMG pursuant to this authorization/assignment by my insurance company shall discharge said insurance company of any and all obligations under the policy to the extent of such payment. I understand and agree that I am financially responsible for charges not covered by this authorization/assignment and I authorize EHMG to contact my employer for the purpose of determining the existence and extent of any insurance benefits.

Initials: _____

Financial Responsibility:

I understand that my insurance company is being billed as a courtesy and I agree that I am financially responsible to pay for any charges not covered by my insurance company. Should my account become delinquent, I agree to pay interest on the outstanding balance owed at the maximum amount permitted by law. If EHMG undertakes collection efforts to recover any past due amounts, I agree to pay all reasonable costs incurred, including attorney's fees.

Initials: _____

Authorization to Release Information to EHMG:

I hereby authorize any insurance company, employer, hospital, physician or utilization review representative to release EHMG any and all information with respect to me or my dependent(s) which may have bearing on my benefits payable by my insurance company for the procedure performed by EHMG on me or my dependent(s). I agree that this authorization shall remain effective for one (1) year from the date indicated below.

Initials: _____

Designation of Authorized Appeal Representative:

I hereby designate EHMG and/or their authorized agents as my authorize representative to pursue my appeal rights.

_____	_____	_____
Patient Signature or Legal Representative	**Print Name**	**Date**

FOR OFFICE USE ONLY:

Acct. type: _____

File Number: _____

REGISTRATION

EmanateHealth™ Medical Group

REGISTRATION FORM

(PLEASE PRINT)

Date _____ Home Phone _____

Cell Phone _____

Patient _____

Last Name First Name Middle

PATIENT INFORMATION

Patient's Social Security Number _____

Responsible Party (if a minor) _____

Street Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Widowed ☐ Divorced

Preferred Language: _____ ☐ Married ☐ Separated

☐ Asian ☐ Hispanic ☐ White ☐ Black

☐ Native American ☐ Native Hawaiian ☐ Other Polynesian ☐ More than one race

☐ Other ☐ Unknown

EMPLOYMENT

Patient Employment By _____

Business Address _____

Occupation _____ Business Phone _____

Spouse (or responsible party) Name _____ Birthdate _____

Who is responsible for this account _____ Relationship to Patient _____

INSURANCE

Do you have Medical Insurance? ☐ No ☐ Yes If yes,

Name of Primary Insurance Co. _____ CoPay _____ Deductible_____

Subscriber # _____ Group # _____ Effective Date _____

Name of Secondary Insurance Co . (if any) _____ CoPay _____ Deductible_____

Subscriber # _____ Group # _____ Effective Date _____

Your Preferred Pharmacy _____

Pharmacy Address _____

Pharmacy Phone _____

In case of emergency, who should be notified _____

Phone _____

How did you learn of our practice? _____

Patient Name: _____ DOB: _____

ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to Emanate Health Medical Group or its representatives, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all allowable charges whether or not they are paid by insurance. I hereby authorize the provider to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

Initials: _____

CONSENT TO TREAT – ADULT

I, the undersigned, do hereby authorize and consent to medical treatment which is deemed advisable and is to be rendered under the general or special supervision of our medical staff. This consent will remain in effect from the date of initiation through the duration of my treatment.

Signature: _____ Date: _____

CONSENT TO TREAT – MINOR

I, the undersigned, parent or guardian of _____, a minor, do hereby authorize and consent to medical treatment which is deemed advisable and is to be rendered under the general or special supervision of our medical staff. This consent will remain in effect from the date of initiation through the duration of my treatment.

Signature: _____ Date: _____

EmanateHealth™ Medical Group

Electronic Communication Consent Form

Purpose: This form is used to obtain your consent to communicate with you electronically regarding your protected health information (PHI).

Emanate Health Medical Group offers patients the opportunity to communicate electronically through our online portal. Carefully consider the following information before granting consent.

Emanate Health Medical Group will use reasonable means to protect the security and confidentiality of health information published. We believe our Emanate Health Medical Group online portal to be secure. However, Emanate Health Medical Group cannot guarantee the security and confidentiality of electronic communication and will not be liable for inadvertent disclosure of confidential information that occurs outside the scope of our security measures. We would encourage you to take appropriate measures when accessing this system. Our Emanate Health Medical Group workstation policy on workstation use further delineates our security measures and defines which employees have access to your medical information.

Patient's Acknowledgment and Agreement

- ☐ I have reviewed the above information and choose NOT to activate my portal account.
- ☐ I acknowledge that I have read and understand this consent form. I understand the risks associated with electronic communication between Emanate Health Medical Group and me. Any questions I may have had were answered. I agree and consent that Emanate Health Medical Group may electronically communicate with me regarding my protected health information (PHI).

Patient Signature: _____ Date: _____

Patient Name: _____

Patient Date of Birth: _____

Patient E-mail Address:

Important: Please CLEARLY PRINT e-mail address
FYI: Our EMR only allows a maximum of 28 characters (including "@" and ".com").

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@ ☐☐☐☐☐☐☐☐☐☐☐☐.☐☐☐

EmanateHealth™ Medical Group

No Show Policy

As a courtesy to our patients we attempt to call the patient/guarantor for an appointment reminder. Calls for appointment reminders are not guaranteed, and the fee is not waived if an appointment reminder is not made.

You will be charged a $25.00 service fee for appointments not cancelled at least 24 work day hours prior to the appointment.

For the second missed appointment – you will be charged $25.00, which is due and payable prior to rescheduling any new appointment.

Late appointment arrivals – If you arrive more than 15 minutes late, we reserve the right to reschedule your appointment, so we may meet the needs of those patients who arrived on time. If this occurs, it will be considered a missed appointment and a $25.00 fee will be charged.

_____ _____

Patient Signature **Date**

Emanate Health™ Medical Group

REQUEST FOR CONFIDENTIAL INFORMATION COMMUNICATION

Emanate Health Medical Group's privacy notice discusses how we may communicate your protected health information to you. We will either mail information to you, attempt to call you, fax information to you, or post information to your patient portal. If you initial or request the fax option, please be aware that your confidential information may be faxed to an unsecure site, i.e. a general fax machine at your home or your office where others may see your information. Please initial the appropriate boxes below informing us how and where we may communicate with you.

MAIL: HOME ☐ OFFICE ☐ OTHER ☐

PHONE: HOME ☐ OFFICE ☐ CELL ☐ OTHER ☐

FAX: HOME ☐ OFFICE ☐ OTHER ☐

PATIENT PORTAL: ☐

INFORMATION MAY BE LEFT WITH AND MY CONFIDENTIAL INFORMATION MAY BE SHARED WITH: ***NAMES MUST BE PROVIDED***

MYSELF ONLY: ☐

HUSBAND/WIFE: _____

CHILDREN/WHOM: _____

PARENTS/WHOM: _____

OTHER: _____

I AUTHORIZE EMANATE HEALTH MEDICAL GROUP TO RELEASE AND SHARE MY CONFIDENTIAL HEALTH INFORMATION AS INDICATED ABOVE.

Signature: _____ Date: _____ Time: _____

Witness: _____ Date: _____ Time: _____