**Patient Information**

**Patient Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Initial Last (Preferred Name)

Sex Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Male Female MM / DD / YYYY Social Security Number Marital Status

(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Phone Email

(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone Work Phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address City, State Zip Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity Preferred Language Race

**Guarantor** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First M.I Last Patient Relationship to Guarantor

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address City, State Zip Code

(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

Guarantor Phone Number Guarantor Work Number

**Emergency Contact** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First M.I Last Relationship to Patient

(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone Number Emergency Contact Work Number

**PRIMARY INSURANCE INFORMATION**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insursance Company Insured Name Relationship to Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Date of Birth Social Security Number Employer Efective date of Insurance

ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ COPAY AMOUNT \_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insursance Company Insured Name Relationship to Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Date of Birth Social Security Number Employer Efective date of Insurance

ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ COPAY AMOUNT \_\_\_\_\_\_\_\_\_\_

**SIGNATURE ON FILE**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Relationship to Patient

**Patient Medical History**

I. **Social History**

1. Smoking: Non-Smoker Current Smoker How many packs per day? \_\_\_\_\_\_\_\_\_

Past Smoker, Quit Date \_\_\_\_\_\_ How many years? \_\_\_\_\_\_\_\_

1. Alcohol Use: None Rare Occasional Frequent Daily
2. Street Drugs: Do you now or have you ever used Street Drugs? Yes No

**II. Major Events / Ongoing Medical Issues**

1. Have you ever had Surgery? Yes No If, YES, specify Surgeries and Dates:

Yes No

Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you now or have you ever had any of the following?

Angina

Yes No

Anxiety

Yes No

Asthma

Yes No

Atrial Fibrillation

Yes No

Arthritis

Yes No

Congestive Heart Failure

Yes No

Depression

Yes No

Diabetes

Yes No

Emphysema (COPD)

Yes No

Fibromyalgia

Yes No

Heartburn

Yes No

Heart Attack

Yes No

Hepatitis

Yes No

High Cholesterol

Yes No

High Blood Pressure

Yes No

Irritable Bowel Syndrome

Yes No

Low Thyroid

Yes No

Migraines

Yes No

Seizures

Yes No

Stroke

Yes No

Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No

Type (please specify)

III. **Allergies**

1. List any Allergies to Medications, metals and foods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IV. **Family Health History**

1. If any blood relative has suffered any of the following, please check the box and indicate which relative

Diabetes Maternal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Paternal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No

Yes No

Yes No

Heart Disease Maternal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Paternal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No

Yes No

Yes No

Stroke Maternal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Paternal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No

Yes No

Yes No

High Blood Pressure Maternal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Paternal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No

Yes No

Yes No

High Cholesterol Maternal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Paternal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No

Yes No

Yes No

Cancer Maternal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Paternal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No

Yes No

Yes No

Family History Unknown Maternal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Paternal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No

Yes No

Yes No

V. **Preventative Care**

1. Vaccine Dates- Please indicate the most recent dates of the following vaccines:

Tetanus / Td \_\_\_\_\_\_ Not Sure

Yes No

Pneumonia \_\_\_\_\_\_ Not Sure

Yes No

Flu Vaccine \_\_\_\_\_\_ Not Sure

Yes No

1. Please indicate if you have had any of the following. If so, include the date and whether the test was normal or abnormal.

Colonoscopy: \_\_\_\_\_\_\_\_\_\_\_\_

Dexa Scan: \_\_\_\_\_\_\_\_\_\_\_\_

Echo: \_\_\_\_\_\_\_\_\_\_\_\_

EKG: \_\_\_\_\_\_\_\_\_\_\_\_\_

Stress Test: \_\_\_\_\_\_\_\_\_\_\_\_\_

Sleep Study: \_\_\_\_\_\_\_\_\_\_\_\_\_

X-rays: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you seeing any Specialists (including OB / GYN) ? YES NO If YES, please list Name and Specialty.

Yes No

Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Female** Patients Only
   1. Date of Last Menstrual Period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Control Method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ None

Yes No

* 1. My periods are: Regular Irregular Heavy

Yes No

Yes No

Yes No

Number of Pregnancies: \_\_\_\_\_\_\_\_\_\_

Number of Live Births \_\_\_\_\_\_\_\_\_\_

Number of Miscarriages: \_\_\_\_\_\_\_\_\_\_

Number of Abortions: \_\_\_\_\_\_\_\_\_\_

* 1. Date of Last Pap Smear: \_\_\_\_\_\_\_\_\_\_ Normal Abnormal

Yes No

Yes No

* 1. Date of Last Mammogram: \_\_\_\_\_\_\_\_\_\_ Normal Abnormal

Yes No

Yes No

VI. **Medications**

1. List All MEDICATIONS you currently take (including over the counter and supplements)
   1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Patient Consent and Signatures**

Consent for treatment and payment at Star Medical

I am an adult or an emancipated minor with legal capacity. If I am a patient’s representative I am properly exercising my authority, and will make available copies of my documents if requested.

I consent to all necessary steps taken for examination, diagnosis, and treatment. If at any time I have questions about my examination, diagnosis or treatment I will not proceed until the questions have been answered so I am fully informed. If surgical or invasive procedures are recommended I may be asked to sign additional consents after being fully informed of the potential risks and benefits.

I understand that giving the doctors and nurses all relevant information is critical to proper diagnosis and treatment. I understand complete compliance with my doctor’s instructions is critical to the success of any treatment prescribed.

I have received a copy of the Star Medical payment policy. I authorize Star Medical to release information to my designated insurance carrier for the purpose of receiving payment. I further authorize the payment of benefits to be made directly to Star Medical on my behalf. I understand a patient is responsible for all charges incurred, subject to contract and program rules, regardless of my insurance status. If it becomes necessary to send this account to collections, the patient will be responsible for all additional charges.

I am signing as the:

Patient Patient representative (mark status below and provide information)

Yes No

Yes No

Parent Spouse Guardian Power of Attorney Next of Kin Other

Yes No

Yes No

Yes No

Y es No

Yes No

Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City, State Zip Code Home Phone Number Work Phone Number

I have read and do understand the above information.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Name Printed Date

**Payment Policy**

Thank you for choosing Star Medical as your medical care provider. Listed below are the payment policies instituted by our office to assist in your care.

**Health Insurance**

As our patient, we want you to be involved in all aspects of your medical care, including financial. You are responsible for verifying and understanding your insurance policy. If your insurance company requires that you select a physician to coordinate your care, that physician’s name must appear on your insurance card. If it does not, you are responsible for having your insurance company contact our office to verify your coverage prior to your appointment.

It is the responsibility of the patient to verify benefits for Preventative Care / Annual Physical Examinations / Screening La work. It is important to verify that these services are covered and how often they can be performed within the policy guidelines. Balances not paid or remaining after insurance pays will be the responsibility of the patient.

If you have had a change in insurance coverage, please inform our office and have that information available at the time of your next appointment.

**Minors**

If the patient is a minor, the person bringing the patient in for the appointment is considered the Guarantor / Responsible party for the account. This is also true in the case of a divorce. If your spouse is responsible to pay medical bills, we will require the insurance card, co pay and / or payment from you and it will be your responsibility to obtain reimbursement from him / her.

**Copay / Deductibles / Self-insured and Outstanding Balances**

Copays / deductibles are due at the time of your visit. For your convenience, we accept cash, checks, credit cards and debit cards. If you have insurance, the normal policies of your plan will apply, including all required extra out of pocket fees (including, but not limited to: copays, deductibles and any fees denied by your insurance company). Non-payment at the time of service will result in an additional 10.00 fee added to your account. If you do not have insurance coverage, your account will be considered self-pay. These accounts are due in full at the time of service. All balances after insurance has been paid must be either paid in full within 30 days or we will make acceptable payment arrangements. If a patient has written a check which returned from the bank for Non-Sufficient Funds (NSF), a 35.00 fee will be assessed to that account and it cannot be billed to insurance. If the patient has a second check NSF with this office, without a viable explanation, that patient will then be required to pay cash at the time of service and our office will no longer accept checks from patient.

Star Medical will file your insurance for office visits on a timely basis. If, however, the account is over 60 days old, the account will be considered self-pay and that patient will be responsible for the outstanding balance. It is the responsibility of the patient to follow up with their insurance carrier to determine the status of the unpaid balance.

**Cancellations**

If you have the need to cancel your appointment, please give the office a reasonable amount of notice so we may make the time available to another patient. One business day prior to your appointment would be greatly appreciated. If the patient has repeatedly failed to cancel scheduled appointments, the patient will be notified in writing stating this issue. On the fourth failed cancellation (no show), the patient will be informed of discharge from the practice.

**Auto Accidents**

Auto accident claims are due in full at the time of service, regardless of who is at fault in the accident claim. If the accident was your fault, we will file the claim with your medical insurance. Upon receipt of payment from your medical insurance, we will reimburse you. If the accident was the fault of another party, we will provide you the necessary documentation to file with the other party’s insurance.

**Assignment of Benefits / Authorization for Treatment**

I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize the payment for all charger incurred, regardless of my insurance status for professional services rendered. I also understand if it becomes necessary for the account / accounts to be sent to collections, I will be responsible for all charges incurred from the collection agency.

**Signature of Patient / Patient Representative**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to Collect, Store, and Use “PHI”**

I have been given a copy of the “Notice of Privacy Protection” by Star Medical. I understand that in order to treat any patient, Star Medical, will have to gather, store and use PHI (Protected Health Information), and that PHI is subject to special federal legal protections. I give my consent to Star Medical to gather, store and use PHI for treatment, billing, and health care operational purposes.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Patient Signature Printed Name           Date

**Acknowledgement of Notice of Privacy Practices**

The law requires that Star Medical make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

I have read or had explained to me Star Medical Notice of Privacy Practice and agree to continue my care with Star Medical under said terms.

Yes No

I was given the opportunity to read Star Medical Notice of Privacy Practices and declined but wish to continue my care with Eye Group under the terms of Star Medical privacy policies.

Yes No

The Notice of Privacy Practice could not be read due to the emergent nature of the care or of other reason described as: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Yes No

**I HAVE READ AND UNDERSTAND THIS FORM.  I AM SIGNING IT VOLUNTARILY.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Patient Signature Printed Name           Date

If you are signing as a personal representative of the patient, please indicate your relationship.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ Representative Signature Relationship to Patient           Date

**Communicating with You**

In order to effectively communicate with you about your medical information we request that you complete this form identifying the best ways to provide you with your confidential information. We may communicate with you through mail, secure email, and telephone, including leaving messages on your answering machine / voicemail.

Please check all the boxes that give Star Medical permission to leave a message on your answering machine or voicemail:

Home: (\_\_\_ )\_\_\_\_\_-\_\_\_\_\_\_\_

Yes No

Work: (\_\_\_ )\_\_\_\_\_-\_\_\_\_\_\_\_

Yes No

Cell: (\_\_\_ )\_\_\_\_\_-\_\_\_\_\_\_\_

Yes No

If you give permission for us to communicate with anyone else, please complete the list below:

**Spouse** No Yes, name of spouse: \_\_\_\_\_\_\_\_\_\_\_\_ **PASSWORD** for “PHI” over the phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No

* es No

Hint: \_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Relationship to Patient** | **Phone Number** | **Options** |
|  |  |  | * Billing Information * Medical / Health Information * Appointment Information |
|  |  |  | * Billing Information * Medical / Health Information * Appointment Information |
|  |  |  | * Billing Information * Medical / Health Information * Appointment Information |