diagnostic group
INTEGRATED HEALTHCARE SYSTEM

PATIENT INFORMATION

Patient Name:_____ _____ _____
Last First Middle Initial

Address:_____ _____ _____
Street or P.O. Box City, State Zip

Date of Birth:_____/_____/_____ Gender: ☐ Male ☐ Female Social Security #:_____ _____ _____
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Spouse's Name_____

Primary Care Physician (PCP or Regular Doctor):_____

Employer:_____ _____
Name Address

_____ _____
City, State, Zip Phone Number

Nearest Relative:_____ _____ _____
Last/First Name Relationship Phone Number

Primary Insurance _____ Policy # _____
Name of Policy Holder_____ Group # _____
SS# of Policy Holder _____ Relation to Policy Holder _____

Secondary Insurance _____ Policy #_____
Name of Policy Holder_____ Group # _____
SS# of Policy Holder _____ Relation to Policy Holder _____

I hereby authorize Diagnostic Group to receive and release any medical or surgical information necessary for the treatment of my medical or surgical conditions in order to process any and all insurance claims on my behalf. I also sign to Diagnostic Group all medical and surgical benefits including major medical to which I am entitled.

I accept responsibility for any unpaid portions of these claims that my health plans do not cover and will make all payments to Diagnostic Group in a timely and conscientious manner. I further understand that it is the policy of Diagnostic Group to provide only appropriate treatment for the diagnosis and therefore, is entitled to appropriate payment for services provided. A $25 charge will occur for any missed visits or returned checks. There will also be a minimum charge of $25 for all requests for medical records other than those requested from other physicians for coordination of care.

I agree that any medical treatment is my financial responsibility. I understand that if I am enrolled in a managed care plan (i.e. HMO, POS), I must have a referral from my primary care physician to be seen by a specialist. All balances on my account that are 60 days overdue must be resolved before another appointment is scheduled. Outstanding balances not resolved within 90 days will be reported for collections and will go against my credit report.

I have been provided the opportunity to review HIPAA policies of this clinic. My acknowledgement of these polices will remain in effect until revoked by me in writing. A photocopy of this acknowledgement with my signature is to be considered valid as original.

_____ _____
Patient Signature or Guardian Signature (if appropriate) Date

Patient Information

Agreement and Consent

Diagnostic Group complies with HIPAA which dictates that our office must do everything possible to protect your medical information. For this reason, please indicate below the names of each family or friend who we can talk to and release your information to regarding appointments, prescriptions, test results, surgery dates and any other medical need we may have.

I request _____ (name of facility)
_____ (address of facility)
to furnish a copy of the medical records of the patient named above for the period of _____ to _____.

I will allow medical information and test results including abnormal results and appointment information released to the following people if they know the code name of _____.
Their hint will be _____.

Name	Relationship	Phone Number

Please indicate the phone number where you can be reached or a message can be left for you during our routine business hours of Monday through Friday, 8:00 am to 5:00 pm.

1. (_____) _____- _____ ☐ home ☐ cell ☐ other _____
2. (_____) _____- _____ ☐ home ☐ cell ☐ other _____

_____I authorize the release of my complete medical record. I understand I have the right to revoke this authorization in writing at any time by sending written notice of revocation to person(s) authorized in paragraph above to disclose the information.

_____ I *do not want any medical information or test results released to anyone but myself.*
(Initial)

I understand that Diagnostic Group is in compliance with HIPAA and has provided me the opportunity to review it in detail. My signature below verifies my understanding of my right. The decisions I have made on this form will be valid until revoked in writing by me.

_____ _____
Signature of Patient/Guardian (if appropriate) Date

_____
Name of Patient (Please Print)

Medical Records and Authorization for Use of Disclosure of Protected Health Information

I hereby authorize _____, M.D.

_____ _____
Address City, State, Zip

_____ to furnish all medical information to:
Phone Number

Diagnostic Group

_____
Physician's Name
3406 College Street
Beaumont, Texas 7701

The information may be used only for the purposes of medical treatment.

I fully understand that the information released may include information about drug or alcohol screens, HIV testing or diagnosis, and psychiatric or psychological testing or diagnosis.

Please print the following information:

Patient Name: _____

Address: _____

_____

Phone # _____

SSN: _____

Date of Birth: _____/_____/_____

_____ _____
Patient Signature Today's Date

Medical Record # _____ (Office Use Only)

I, _____, understand that my insurance co-payment is due at the time of service. Diagnostic Group will file a claim with my medical insurance company for services rendered. I understand that after payment is received, there may be charges that are not paid and/or covered by my insurance plan. These include but are not limited to:

- Medical Insurance Deductible
- Co-Insurance or Out-of-Pocket amount
- Unauthorized Medical Visit
- Provider is Out of Network
- Services provided are not covered under my medical plan
- Medical insurance is not active

I agree to be financially responsible for all charges not covered by my medical insurance plan for services rendered by this physician of Diagnostic Group.

_____ _____

Patient Signature Date