

MGHS—CLINIC PATIENT CONSENT FORM

M.R. #: _____

PATIENT REGISTRATION AND FAMILY INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____

Mailing Address: _____ Gender: _____ Marital Status: _____

City / State / Zip: _____ Social Security Number _____

Home Telephone: _____ Cell Phone _____

Patient's Employer: _____ May we call you at work? Yes No. Work telephone: _____

Emergency Contact Person: _____ Phone Number: _____

1. Parent, Spouse, nearest

Relative or Guardian: _____ Relationship to Patient: _____

Mailing Address: _____ Home Phone: _____

Occupation/Employer: _____ Work Phone: _____

2. Parent, Spouse, nearest

Relative or Guardian: _____ Relationship to Patient: _____

Mailing Address: _____ Home Phone: _____

Occupation/Employer: _____ Work Phone: _____

OFFICE STAFF WILL PHOTOCOPY YOUR INSURANCE CARDS

INSURANCE POLICY HOLDER INFORMATION

INSURANCE POLICY HOLDER INFORMATION

1st Insurance Co. (Primary): _____ 2nd Insurance Co. (Secondary): _____

Policy Holder Name: _____ Policy Holder Name: _____

Policy Holder SS #: _____ Policy Holder SS #: _____

Policy Holders Date of Birth: _____ Policy Holders Date of Birth: _____

Relationship to Patient: _____ Relationship to Patient: _____

Policy Holders Employer: _____ Policy Holders Employer: _____

AGREEMENT FOR EXAMINATION AND/OR TREATMENT

I hereby agree and consent to be examined and treated by my physician. I understand I have the right to participate in decisions involving my health care. In the event I may be harboring an infectious disease such as Hepatitis B or Human Immunodeficiency Virus (HIV) which could endanger the health of individuals accidentally exposed to my blood or body fluids, I do hereby voluntarily consent to such routine diagnostic procedures and care provided by Marquette General Health System as is deemed necessary by my physician (or his designee) or by the staff of the Clinic. I further understand that any test results will become part of my medical record, and as such its confidentiality is protected by Federal Law.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize release of clinic medical records relevant to examination and/or treatment including laboratory reports and x-rays, to the consulting and/or referring physician or agency, to the source(s) of continuing care, including Marquette General Health System physicians, facilities, and Clinics. I also authorize the release of these records to any insurance carrier, government agency or unit, or third party payor, in any way involved in the payment of all or any part of the clinic bill.

I hereby assign payment directly to the above named, Marquette General Health System, of authorized benefits to be made in my behalf not to exceed the balance due of the physician's regular charges. I understand that I am financially responsible to Marquette General Health System for charges not covered by this authorization under the provisions of the Federal Truth in Lending Law, 7169.

OPTIONAL AUTHORIZATION TO RELEASE INFORMATION

I, _____, give Marquette General Health System Clinic, permission to speak with the following people regarding my medical and/or financial information. This authorization is valid until such time as I provide MGHS written revocation of it.

_____	_____	Please circle: Financial Medical
Name and Phone Number	Relationship to Patient	
_____	_____	Please circle: Financial Medical
Name and Phone Number	Relationship to Patient	

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT (ONE TIME USE)

The Notice of Privacy Practices for Marquette General Health System has been made available to me for my review. I understand that I may request a copy of the notice or obtain a copy from their website at www.mgh.org at any time.

X _____
 Patient/Representative Signature Date

ADVANCE DIRECTIVES

Does patient have written Advance Directive: Yes No

Further information requested by patient: Yes No/declined

Annual offer of Advance Directive:
 Date: _____
 Date: _____
 Date: _____

Is copy on file in clinic chart? Yes No

Date Copy Requested from patient _____
 Date Copy Requested from patient _____
 Date Copy Requested from patient _____

I HAVE READ THIS CONSENT FORM AND I AM FULLY AWARE OF AND AGREE TO THE CONTENTS. THIS FORM IS VALID FOR ONE YEAR FROM THE DATE OF THE MOST RECENT SIGNATURE.

X _____	_____	_____	_____
Insured/Patient/Guardian (if minor or incompetent)/Guarantor	Dated	Witness	Dated
X _____	_____	_____	_____
Insured/Patient/Guardian (if minor or incompetent)/Guarantor	Dated	Witness	Dated
X _____	_____	_____	_____
Insured/Patient/Guardian (if minor or incompetent)/Guarantor	Dated	Witness	Dated