UPHS–CLINIC PATIENT CONSENT FORM

I.D. #:_____

PATIENT REGISTRATION AND FAMILY INFORMATION

Patient Name _____
(Last-Jr., Sr., III) (First) (Middle Init)

Previous Names:_____ Date of Birth:_____ Age: _____

Mailing Address:_____ Gender:_____ Marital Status:_____

City / State / Zip: _____ Social Security Number _____

Home Telephone:_____ Cell Phone _____ Email Address: _____

(We may use this information to contact you.)

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

Emergency Contact Person:_____ Phone Number: _____

Race/Ethnicity (circle one): Asian/Pacific Islander Black Caucasian Hispanic American Indian Alaskan Native Declined Other _____

Preferred Language: English Other _____

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

1st Insurance Co. (Primary): _____

Policy Holder Name: _____

Policy Holder SS #:_____

Policy Holders Date of Birth: _____

Relationship to Patient: _____

Policy Holders Employer:_____

INSURANCE POLICY HOLDER INFORMATION

2nd Insurance Co. (Secondary):_____

Policy Holder Name: _____

Policy Holder SS #:_____

Policy Holders Date of Birth: _____

Relationship to Patient: _____

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 UP Health System – Marquette 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 any and all clinic medical records relevant to my examination and/or treatment, including laboratory and other interpretative reports and x-rays, to (a) the consulting and/or referring physician or agency or (b) the source(s) of continuing care, including but not limited to practitioners on the UP Health System – Marquette medical staff, its facilities and clinics. I also authorize the release of these records for any payment or quality management related purpose to any (a) insurance carrier, (b) government agency or unit, or (c) any third party payor in any way involved in the payment for all or any part of my health care.

I hereby assign payment directly to the above named, UP Health System – Marquette, 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 UP Health System – Marquette for charges not covered by this authorization under the provisions of the Federal Truth in Lending Law, 7169.

ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION

I authorize the healthcare provider to provide a copy of the medical record of my treatment, the discharge summary, and/or a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) identified in my plan of care to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the healthcare provider, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

OPTIONAL AUTHORIZATION TO RELEASE INFORMATION

I, _____, give UP Health System – Marquette Clinic, permission to communicate with the following people regarding my medical and/or financial information. This authorization is valid until such time as I provide UPHSM 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 UP Health System – Marquette 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

PATIENT RIGHTS AND RESPONSIBILITIES *(Offer Annually)*

_____ **PATIENT'S RIGHTS AND RESPONSIBILITIES** have been made available to me and I have read and understand these rights and responsibilities.
Pt. Init

_____ I have declined a copy of the **PATIENT'S RIGHTS AND RESPONSIBILITIES** and am aware that they are available to me at www.mgh.org or on request in the future.
Pt. Init.

ADVANCE DIRECTIVES *(Offer Annually)*

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