



## Patient Information / Consent to Treatment

|                    |             |                |                 |
|--------------------|-------------|----------------|-----------------|
| Patient Name:      |             | Date of Birth: | Date:           |
| Address:           |             |                |                 |
| Home Phone:        | Work Phone: | Cell Phone:    |                 |
| Social Security #: | Age:        | Sex:           | Marital Status: |

|                    |               |                 |             |             |
|--------------------|---------------|-----------------|-------------|-------------|
| Employer Name:     |               | E Mail Address: |             |             |
| Emergency Contact: | Relationship: | Home Phone:     | Work Phone: | Cell Phone: |

### Responsible Party (If under 18):

|                           |               |             |             |             |
|---------------------------|---------------|-------------|-------------|-------------|
| Name:                     | Relationship: | DOB:        | SS#:        |             |
| Responsible Party Address |               | Home Phone: | Work Phone: | Cell Phone: |

### INSURANCE INFORMATION

I verify that: \_\_\_\_\_ (insurance company) is my current insurance and the information I have given to South Point Family Practice is correct. I understand that I am responsible for any charges in the event the information I have given is incorrect and for correcting the insurance information.

Primary Insurance:  
 Subscriber #: \_\_\_\_\_ Group#: \_\_\_\_\_  
 Secondary Ins:  
 Subscriber \_\_\_\_\_ Group#: \_\_\_\_\_

#### *Financial Responsibility and Assignment of Insurance Benefits:*

I guarantee payment to South Point Family Practice and its affiliates of all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits, which would otherwise be payable to me, to South Point Family Practice for services rendered. If covered By Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct.

#### *Consent for Healthcare and Release of Medical Information*

I voluntarily consent to healthcare treatment ("Treatment") from the physicians and staff at South Point Family Practice. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatments of examination by my caregivers. I consent to the use and disclosure of protected health information about me for treatment, payment, and healthcare operations. I have read this form. I have had the opportunity to ask questions and my questions have been answered

Signature of Patient or  
 Authorized Person: X \_\_\_\_\_ Date: \_\_\_\_\_

Insured Party or Financial Guarantor  
 if different from above: \_\_\_\_\_ Date: \_\_\_\_\_