UPHS CLINIC | PATIENT CONSENT FORM

Patient Registration & Family Information:

PATIENT NAME: _____
(Last, Jr., Sr., III) *(First)* *(Middle)*

PREFERRED NAME: _____ **PREVIOUS NAMES:** _____ **DATE OF BIRTH:** _____ **AGE:** _____

MAILING ADDRESS: _____ **GENDER IDENTITY:** _____ **GENDER ASSIGNED AT BIRTH:** _____

CITY / STATE / ZIP: _____ **MARITAL/PARTNER STATUS:** _____

PHONE: _____ **CELL:** _____ **EMAIL:** _____

EMPLOYER: _____ **MAY WE CALL AT WORK?** ☐ **YES** ☐ **NO** **WORK PHONE:** _____

RACE/ETHNICITY: *Asian/Pacific Islander Black Caucasian Hispanic American Indian Alaskan Native Declined Other:* _____

PREFERRED LANGUAGE: *English Other:* _____ **SOCIAL SECURITY #:** _____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____ **PHONE:** _____

1. PARENT, SPOUSE, NEAREST RELATIVE/GUARDIAN: _____ **RELATIONSHIP:** _____

MAILING ADDRESS: _____ **PHONE:** _____

EMPLOYER: _____ **WORK PHONE:** _____

2. PARENT, SPOUSE, NEAREST RELATIVE/GUARDIAN: _____ **RELATIONSHIP:** _____

MAILING ADDRESS: _____ **PHONE:** _____

EMPLOYER: _____ **WORK PHONE:** _____

Insurance Information: *(Staff will photocopy insurance cards)*

Can be left blank if copy of card attained

1st INSURANCE POLICY CO. (Primary): _____ **2nd INSURANCE POLICY CO. (Secondary):** _____

POLICY HOLDER NAME: _____ **POLICY HOLDER NAME:** _____

POLICY HOLDER SS#: _____ **POLICY HOLDER SS#:** _____

POLICY HOLDER DATE OF BIRTH: _____ **POLICY HOLDER DATE OF BIRTH:** _____

RELATIONSHIP TO PATIENT: _____ **RELATIONSHIP TO PATIENT:** _____

EMPLOYER: _____ **EMPLOYER:** _____

AGREEMENT FOR EXAMINATION AND/OR TREATMENT

I hereby agree and give 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 bodily 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/her 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 the release of any and all clinic medical records relevant to my examination and/or treatment, including laboratory and other interpretive 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 of 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 my of the medical record of my treatment, the discharge summary, and/or a summary or 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 UP Health System 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 ACKNOWELEDGEMENT *(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 ww.mgh.org at any time.

_____

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 **Patients 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 FOR ONE YEAR FROM THE DATE OF THE MOST RECENT SIGNATURE.

X _____

Insured/Patient/Guardian (if minor or incompetent)/Guarantor *Dated*

X _____

Insured/Patient/Guardian (if minor or incompetent)/Guarantor *Dated*

X _____

Insured/Patient/Guardian (if minor or incompetent)/Guarantor *Dated*