MGHS–CLINIC PATIENT CONSENT FORM

I.D. #:_____

PATIENT REGISTRATION AND FAMILY INFORMATION

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

Maiden Name: _____ 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 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 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 Marquette General Hospital 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, 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

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