

DICKSON MEDICAL ASSOCIATES, PC
700 Form

Date _____

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Physician _____

Patient Chart Number _____ Patient Race _____

Patient Legal Address _____

Home Phone _____ Cell Phone _____

Work Phone _____

Social Security Number _____ Date of Birth _____

ER Contact _____ ER Phone _____

Referring Physician _____

Person Responsible for payment _____

Responsible's Address _____

Responsible's Employer _____

Employer's Address _____

Employer's Phone _____

Responsible's Social Security Number _____

Primary Insurance Name _____ Plan Name _____

Policy Number _____ Group _____

Insurance Address _____

Subscriber's Social Security Number _____

Subscriber's Date of Birth _____

Secondary Insurance Name _____ Plan Name _____

Subscriber's Name _____

Policy Number _____ Group _____

Insurance Address _____ 27

Do you have a living will or a Durable Power of Attorney for Healthcare?

YES or NO

AUTHORIZATION

I certify that I have reviewed the information listed above and confirm that it is true and correct to the best of my knowledge.

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Dickson Medical Associates, PC for any services furnished to me by that provider.

I authorize any holder of medical information about me to release to the Centers for Medicaid and Medicare or other insurance carriers and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature

Date

I understand and agree to be personally and fully responsible for payment if my health insurance denies payment for services rendered, due to: **my PCP is not a provider with this group; a referral/precertification has not been issued for the service; my insurance is not in effect for the date of service; or if these services are non-covered for any reason.**

Signature

Date

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Patient Name _____ Chart Number _____
Patient Social Security Number _____ Date of Birth _____

HIPAA PRIVACY ACT

Federal Regulation called Health Insurance Portability and Accountability Act requires us to provide you with the opportunity to review our Privacy Notice. This notice provides you information about how we may use and disclose Protected Health Information about you.

Your response to the following questions will give us permission to contact you at home and/or work (if you so desire) and to whom we may disclose your medical information, other than outlined in the Notice of Privacy Practices.

May we call you at home?
May we leave a message on your answering machine?
May we disclose your PHI to anyone other than yourself?
If so, who may we speak with?
May we call you at work?
Messages will not be left at work.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practice for Protected Health Information.

Signed this the _____ day of _____, 200__.

Signature of Patient or Representative Relationship to patient

Witness

Employee: The information contained herein must NOT be modified without the consent and signature of the patient or patient representative. No verbal modifications permitted.