PATIENT INFORMATION **Update** **New Patient** Date_____ Physician_____

Last Name _____ First Name _____ Middle Initial _____

Nickname _____ Suffix I II III Jr Sr Date of Birth _____

Gender Male Female Social Security Number _____ Separated Divorced Married Single Widow

Home Phone _____ Work Phone _____ Ext _____ Cell Phone _____

Mailing Address _____ City _____ State _____ Zip _____ **Physical** Address _____ City _____ State _____ Zip _____

Living Will Yes No E-mail Address _____ Pharmacy Preference _____

Emergency Contact_____Relationship_____Phone#_____ Cell #_____

GUARANTOR INFORMATION

Relationship to Patient _____

Last Name _____ First Name _____ Middle _____

Date of Birth _____ Social Security Number _____ Separated Divorced Married Single Widow

Mailing Address _____ City _____ State _____ Zip _____ **Physical** Address _____ City _____ State _____ Zip _____

Guarantor Employer _____ Address _____ City _____ State _____ Zip _____ Phone Number _____

INSURANCE INFORMATION

Primary Insurance Company Name _____ Address _____

Group Number _____ ID Number _____

Policy Holder Name _____ Social Security Number _____ Date of Birth _____

Secondary Insurance Company Name _____ Address _____

Group Number _____ ID Number _____

Policy Holder Name _____ Social Security Number _____ Date of Birth _____

Signature of Patient, Guardian or Authorized Agent _____

Medical Record #_____

STEVENS COUNTY HOSPITAL/MEDICAL CLINIC
ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Stevens County Hospital/Medical Clinic's Notice of Privacy Practices with the effective date of April 14, 2003. This acknowledgment is also applicable for all minor children named below of whom I am parent/guardian.

_____ _____

Signature of Patient/Patient Representative Date

_____ _____

Name (Printed) Relationship to Patient

Names of Minor Children

_____ _____

_____ _____

Original to be maintained in Patient's permanent medical record.

04/14/03

STEVENS COUNTY MEDICAL CLINIC

Authorization to release information and assignment of insurance benefits

THIS IS GOOD FOR ONE YEAR FOR ALL APPOINTMENTS DURING THE YEAR FOR MYSELF OR FAMILY MEMBERS THAT I AM THE GUARANTOR

Patient (Last Name) (First Name) (Middle Initial) D.O.B.

I request that payment of authorized Medicare benefits and/or my private insurance benefits be made on my behalf to Stevens County Medical Clinic for services furnished by Clinic physicians and staff. I permit a copy of this authorization to be used in place of the original and authorize any holder of medical information about me to release to the related services. As a non-Medicare patient, I understand that I am financially responsible for all remaining charges not covered by my insurance plan(s). As a Medicare patient, I am financially responsible for the remaining portion not paid by Medicare and for other routine health services. As a non insured patient I am financially responsible for the treatment received at Stevens County Medical Clinic.

The undersigned patient or responsible party hereby consents to medical treatment which Stevens County Medical Clinic Providers deem necessary. I, as the patient or responsible party, also authorize the release of medical information to other health care providers as may appear necessary for the welfare of such patient.

A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

Signature of patient, guardian or authorized agent

Date

Relationship to patient

Stevens County Healthcare
For the Heartland

PERMISSION FOR RELEASE OF INFORMATION

I _____ give the following family members
(Patient Name)
and /or friends listed below, permission to call into Stevens County Medical Clinic to speak with my Doctor or Nurse concerning my health, test results, medication, etc. until further notice is given.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____
Signature Date

_____ _____
Witness Date