MIDWAY
SPECIALTY CARE CENTER

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) request that we ask your permission before disclosing certain healthcare information to certain people or entities.

In accordance with Act, I _____ (patient name) hereby authorize Midway Specialty Care Center to release any information regarding my health to the following persons or entities:

_____
_____
_____
_____
_____
_____

In the event that I am not home when Midway Specialty Care Center calls with medical information:

_____ Please **DO** leave messages on my answering machine

_____ Please **DO NOT** leave messages on my answering machine

_____ I **DO NOT HAVE** an answering machine

Patient Name _____

Patient Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and/or indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact the organization at any time at the address above to obtain current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date Signed: _____

OFFICIAL USE ONLY

I attempted to obtain the patient's signature acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Initial: _____ Date: _____

Reason: _____

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When registering in our office, please present your insurance cards, any forms (completed and signed) and your referral if you have HMO insurance.

Patient's Name (First/Middle/Last):	Social Security #:	DOB (MM/DD/YYYY):	Age:	Marital Status: S M W D Sep	Gender: M / F
Address:	City & State:	Zip Code:	Home Phone: ( )		
Email Address:			Cell Phone: ( )		
Employer:		Occupation:			
Employer Address:	City & State:	Zip Code:	Business Phone: ( )		

If patient is a minor or student, please complete below:

Mother's Name(First/Middle/Last):	Mother's SS#:	Mother's DOB:	Mother's Employer:
Mother's Employer's Address:	City & State:	Zip Code:	Business Phone: ( )
Father's Name(First/Middle/Last):	Father's SS#:	Father's DOB:	Father's Employer:
Father's Employer's Address:	City & State:	Zip Code:	Business Phone: ( )

Name of Family Doctor:	Name of Referring Doctor	
Emergency Contact:	Phone: ( )	Relationship

Please complete insurance information on next page.

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HEALTH	Name of Primary Insurance:	Address of Company:	
	ID Number:	Group Number:	
	Name of Subscriber to Insurance:	Subscriber's SS#	Subscriber's DOB:
	Name of Secondary Insurance:	Address of Company:	
	ID Number:	Group Number:	
	Name of Subscriber to Insurance:	Subscriber's SS#	Subscriber's DOB:
RX	Name of RX Insurance:	ID Number: RX Group Number:	
	Address of Company: Phone Number:	RX Bin Number: RX PCN Number:	
INJURY	Work (Company): Name of Auto : Name of Lawyer:	Date of Injury :	
	Claim Number : Phone Number:	Address:	

Please Read: All charges are payable at the time of service. If hospitalization is indicated, the patient is responsible for furnishing insurance claim forms to the office prior to hospitalization.

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage, it is also customary to pay for services when rendered unless other arrangements have been made in advance with our Billing Department.

Insurance Authorization and Assignment

I hereby authorize Midway Specialty Care Center to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the Midway Specialty Care Center all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Please be aware that if you have an HMO Plan a referral must be obtained from your Primary Care Provider for each of your visits. If one is not obtained, you will be held fully responsible for all charges.

Signature :_____ Date:_____

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I, _____, Social Security #_____,

D.O.B. _____, hereby authorize the release of all my medical records, including but not limited to x-rays, laboratory test, diagnostic test, physician/nurses/notes, and HIV related information from/to:

Physician's Name: _____

Physician's Address: _____

Physician's Phone: _____

Physician's Fax: _____

Please forward the information at your earliest convenience.

_____ _____

Patient's Signature Date

_____ _____

Witness Date

_____

Relationship