Rettig Family Health Care

a Limestone Medical Center Clinic

PATIENT DEMOGRAPHIC INFORMATION

**** PLEASE PRINT ****

Patient's Name:_____ SS#:_____
Last Name First Name M.I.

Mailing Address:_____City/State/Zip: _____

Physical Address **(no P.O. boxes)**: _____

Pharmacy:_____

E-mail:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Sex: ____ M _____ F Age: _____ Birth date: _____ Marital Status: M S D W

Race: □ American Indian or Alaska Native □ Asian □ Black or African American □ Caucasian

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Employer/School: _____ Occupation: _____

Employer/School Address: _____ Phone: _____

PARENT/GUARDIAN (if under 18)

NAME: _____

DOB: _____

SS#: _____

EMERGENCY CONTACT

NAME: _____

PHONE NUMBER: _____

RELATIONSHIP TO PATIENT: _____

INSURANCE

**** PLEASE PRESENT YOUR INSURANCE CARD WHEN YOU CHECK IN FOR EVERY VISIT ****

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Policy Holder's SSN: _____

Policy Holder's Relationship to Patient: _____

ASSIGNMENT AND RELEASE

I, the undersigned, authorize Dr. _____ to release to _____any and all medical information, of whatever nature, now in their possession or later acquired, from whatever source, which pertains or is related to my medical care. This authorization and consent is granted for the sole and limited purpose of facilitating the quality assurance and quality improvement activities conducted by the health plan. I understand and agree that by consenting to and granting this authorization, I am releasing those rights and claims of confidentiality and privilege concerning the information described which may otherwise exist when used for thepurposes described. I future understand and agree that I may withdraw my authorization and consent at any time by written notice of withdrawal to the health plan, provided, however, that any such withdrawal will not affect any information disclosed prior to receipt by the health plan of the written notice of withdrawal.

Signature:_____Date:_____

Rettig Family Health Care

Please read and sign only the sections that apply. The consent section must be signed before treatment can be given.

MEDICARE CERTIFICATION / BENEFICIARY SIGNATURE REQUIREMENT

I certify that the information given by me in applying for payment under Title SVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Date:_____ Signature:_____

MEDICAID CERTIFICATION

I understand that, in the opinion of **Rettig Family Health Care**, the services or items that I have requested to be provided to me may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the Texas Department of Human Services or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

Date:_____ Signature:_____

CONSENT FOR TREATMENT

The undersigned hereby makes the following acknowledgments regarding the treatment of his/her medical problems.

1. **CONSENT FOR TREATMENT:** I, the undersigned, as the patient or on the behalf of the patient whose name appears below, do hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of my provider. I understand that the treatment only is being provided, during the published hours of operation, and that no responsibility will be taken for long term patient care.
2. **NO GUARANTEE OF RESULTS:** I understand that no guarantee or assurance has been made as to the results which may be obtained.
3. **AGREEMENT TO PAY FOR THE SERVICES RENDERED:** I agree that I, the undersigned, will be responsible to Rettig Family Health Care for all charges incurred for services rendered in my medical-surgical care if these charges are not covered or approved under Medicare, Medicaid, Private Insurance, or Indigent Health Care Plans. I also agree to provide all necessary information true to reimbursements under such insurance plans.

I have read the above, and fully understand the same.

Date:_____ Patient Signature:_____

OR Patient's Representative:_____

Relationship to Patient:_____

Rettig Family Health Care

Acknowledgement of Receipt of Privacy Policies

I have received a copy of the privacy policy for Rettig Family Health Care in accordance with the Health Insurance Portability and Accountability Act of 1996. I understand concerns and questions regarding these policies may be directed in writing to Rettig Family Health Care.

_____

Printed Name of the Patient

_____ _____

Signature of Patient Date

AUTHORIZED REPRESENTATIVE

I, _____, (the insured), have health insurance benefits through _____ _____ that are provided to me by the following named employer _____ _____, that is engaged in commerce, as defined in 29 USC 18§§1003. I do hereby designate ***Rettig Family Health Care, a Limestone Medical Center Clinic,*** to be my authorized representative as defined in Federal Regulation 29 CFR 2560-503-1, to fully act on my behalf to submit my claim(s) for healthcare benefits payments, to obtain any and all information from my health insurance company that will be used in an appeals of my adverse benefit determination, as defined in 29 CFR 2560-503-1, and to represent me in a Federal Court of Law, to appeal any and all adverse benefit determinations and any and all actions to ensure that my employer provided health benefit payments are correctly paid. My health insurance company is to provide ***Rettig Family Health Care, a Limestone Medical Center Clinic,*** with any and all requests for the discovery of any and all documents used by _____ to deny my health benefit payment when not paid in full. If any outside policies or consultants were used to perform the adverse benefit determination, _____ is directed to provide my authorized representative with a legible copy of said policy, the name and specialty of the person of any consultants, and any and all documents provided by said consultant. My authorized representative is authorized to file grievances with any and all applicable State or Federal regulatory agencies and to represent me in any legal action in a Federal Court of Law. Copies of this authorization are to be treated as if it were the original document.

_____

Signature of Insured Date

Assignment of Benefit Form

I, (_____), hereby assign my healthcare benefit payments, to which I am entitled through (_____) to **Rettig Family Health Care, a Limestone Medical Center Clinic,** ("assignee").

This assignment is pursuant to the Employee Retirement Income Security Act (ERISA) as defined in 29 CFR 2560-503-1, and applicable State law, and it will remain in effect until revoked by me in writing.

I understand that I am financially responsible for all charges not paid by my insurance. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits.

Rettig Family Health Care, a Limestone Medical Center Clinic, is hereby authorized to initiate on my behalf any complaints regarding my healthcare benefit payments or adverse benefit determinations as defined in 29 CFR 2560-603-1, with the State Insurance Commissioner for a possible violation of State Insurance Laws or the Employee Benefit Security Administration and the Secretary of Labor as it pertains to ERISA, specifically 29 USC 18§§1003(a) and 1144(a).

Rettig Family Health Care, a Limestone Medical Center Clinic, is allowed full discovery of any and all information, documentation, policies, procedures, and resources used by (_____), to perform and adverse benefit determination, as defined 83 CFR 2560-503-1 of my covered health benefits.

Rettig Family Health Care, a Limestone Medical Center Clinic, is authorized to represent me in any and all Federal Lawsuits against my insurance company (_____) pursuant to the ERISA. A copy of this document is as valid as the original.

_____

(Signature of Patient/Insured) (Date)

_____

(Printed Name of Patient/Insured)

_____

(Signature of Witness) (Date)

_____

(Printed Name of Witness)