Rettig Family Health Care

a Limestone Medical Center Clinic

PATIENT DEMOGRAPHIC INFORMATION

**** PLEASE PRINT ****

Patient's Name:_____ S.S.#:_____

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

Language: □ English □ Spanish □ Mandarin □ Other:_____

Employer/School: _____ Occupation: _____

Employer/School Address: _____ Phone: _____

PARENT/GUARDIAN (if under 18)

NAME: _____

DOB: _____

S S #: _____

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: _____

HOW DID YOU HEAR ABOUT US?

☐ Word of Mouth ☐ Facebook ☐ Website ☐ Newspaper ☐ Other:_____

Signature: _____ Date:_____

Rettig Family Health Care
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Acknowledgement of Receipt of Privacy Policies

I have received a copy of the privacy policy for Rettig Family Health Care, a Limestone Medical Center Clinic, 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
(the insured)

_____ that are provided to me by the following named employer
(insurance company)

_____, that is engaged in commerce, as defined in 29 USC 18§§1003. I do
(employer)

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
(insurance company)

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
(insurance company)

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
(patient name)

through _____ to **Rettig Family Health Care, a Limestone Medical Center Clinic,**
(insurance company)
("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
(insurance company)
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)

Patient Consent Form

Rettig Family Health Care
A Limestone Medical Center Clinic

Authorization for Care: I grant permission to the employees of Rettig Family Health Care, a Limestone Medical Center clinic, to examine, treat, and perform diagnostic tests and procedures that my provider deems necessary.

Authorization of Care by PA/NP: I understand that my care may be provided by a Physician Assistant or Nurse Practitioner in consultation with a physician. There may or may not be a doctor of medicine or osteopathy present in the clinic 24 hours per day, seven days a week. My signature on this form constitutes my consent to treatment by this professional.

Assignment of Benefit: Insurance Assignment: In consideration of services rendered, I hereby assign and transfer to Rettig Family Health Care, a Limestone Medical Center clinic, any benefits payable for my benefit under hospitalization, sickness or accident insurance, and any other insurance coverage, to include major medical, for the payment of services rendered.

Financial Agreement & Responsibility: I understand that, regardless of my assigned benefits, I am responsible for all charges. I understand that Rettig Family Health Care, a Limestone Medical Center clinic, may file a claim for benefits on my behalf but, whatever my coverage, it is a personal contract between me and my insurance company. If benefits are not paid, I will be billed for the entire balance which I must pay in full upon receipt of the statement. I understand that I am responsible for charges not covered by this assignment and / or not paid by said companies and payers.

Medicare Lifetime Authorization: By signing below, I authorize any holder of medical or other information about me to release to the Social Security Administrations and Health Care Financing Administration of the intermediaries or carrier any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and requested payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I further understand that I will assume full responsibility for any medical costs not covered by Medicare.

Non-Smoking Facility: I understand this is a non-smoking facility and I will abide by this policy.

Valuables: I understand that Rettig Family Health Care, a Limestone Medical Center clinic, is not responsible for personal items (dental items, eye wear, jewelry, clothing, etc.) electively kept in my room or designated area while I am a patient. I further understand that patient care items left in the room following discharge will be disposed of and not replaced by Rettig Family Health Care, a Limestone Medical Center clinic.

HIV, HBV, and HCV Testing After an Accidental Exposure: Texas law authorizes a hospital or physician to require that a patient be tested for possible exposure to the Human Immunodeficiency Virus, Hepatitis B virus and Hepatitis C virus in the following situations: (1) if donation of blood, blood products, organs, or tissues is contaminated; (2) if a healthcare worker is accidentally exposed to a patient's blood or bodily fluids; or (3) if a medical surgical procedure is to be performed which could expose health care workers to the patient's blood or bodily fluids. This disclosure informs that you may be tested if any of these situations occur during your hospitalization. I consent to HIV, HBV & HCV testing under any of the above situations.

Privacy Practices: Rettig Family Health Care, a Limestone Medical Center clinic, is required by law to maintain the privacy of a patient's protected health information (PHI). In addition, we are required by law to provide individuals with a notice of our legal duties and privacy practices, if requested, with respect to PHI.

Patient Rights and Responsibilities: I have been given the opportunity to review my rights and responsibilities as a patient. I understand my rights because they have been explained to me and my questions have been answered.

Authorization to Release Information: By signing below, I authorize Rettig Family Health Care, a Limestone Medical Center clinic, to release information requested by insurance companies, review agencies or other third-party payers for payment of claims arising out of this visit. **I give permission, without limitation or exclusion, for Rettig Family Health Care, a Limestone Medical Center clinic, and its providers to view my external prescription history for purposes of my care and treatment.** I understand that my medication history from multiple other medical providers, insurance companies, and pharmacy benefit managers may be viewable and that granting this permission will allow my providers to better coordinate my care and to maximize the effectiveness and safety of my treatment plan.

Signature of Patient or Patient's Representative	Relationship to Patient	Date

Staff Signature

Rettig Family Health Care
a Limestone Medical Center Clinic

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date: _____

I _____ authorize Rettig Family Health Care to release any medical information (including diagnostic information, lab results, and radiology reports) to the person(s) listed below.

I understand that if I do not list anyone below, no information will be given to anyone other than myself.

_____ _____

Patient Signature (parent/guardian if patient is a minor) Patient Printed Name (parent/guardian if patient is a minor)

Relationship to Patient ☐ Self ☐ Other _____

Information can be released to:

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

_____ _____

Witness Signature Witness Printed Name

Rettig Family Health Care

A Limestone Medical Center Clinic

204 W. Trinity Street • Groesbeck, TX 76642 • Phone: (254) 729-3740 • Fax: (254) 729-2315

MEDICAL RECORDS RELEASE CONSENT

Patient Name: _____

Patient Address: _____

City, State, Zip: _____

Date of Birth: _____

This authorizes to release or disclose information from the records of the above-named patient to/from:

To: _____

Address: _____

City/State: _____

Phone: _____

Fax: _____

From: _____

Address: _____

City/State: _____

Phone: _____

Fax: _____

The purpose of this disclosure is: _____

If faxing, send records to: (254) 729-2315

**** If over 50 pages, please email records to lanie.lloyd@lmchospital.com or call (254) 729-3740 if you cannot email records. DO NOT FAX records if over 50 pages ****

The consent of disclosure is subject to revocation at any time except to the extent that action has been taken in reliance thereon (i.e. information already disclosed). My signature means that I have read this form and/or have had it read to me and explained in language that I can understand. I hereby release the above from any legal liability resulting from the release of this information. The consent of disclosure will expire ninety (90) days after the termination of therapy, or as otherwise specified by date, even, or condition as follows, unless previously revoked by me.

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

Signature of Staff Member: _____

TO THE RECEIVING PARTY OF THIS INFORMATION: This information has been disclosed to you from the records protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 FCFR Part 2.