Request for confidential communication

I___________________________ hereby request Family Medical Care, LTD to keep my
(NAME OF PATIENT OR AUTHORIZED AGENT)

communications regarding my protected health information confidential. To accomplish this request please adhere to the following requests:

Phone: You can contact me by phone at Home________________________________

Work_________________________________

Cell Phone ___________________________

Leave message on answering machine: ______Yes _____No

Leave Message with any other person: _______Yes ______No

Name of Other: ______________________________________

Mail: contact me at the following address: ________________________________

____

If unable to contact you by phone we will send a letter/certified letter

Fax: ______Please do not contact me by Fax

______Please contact me by Fax at ____________________

Other Requests for Confidential Communication: __________________________________

*____

*____

Signed: ____Date: ____________________

If you are not the patient, please specify your relationship to the patient______________

--Patient's file

FAMILY MEDICAL CARE, LTD

PATIENT REGISTRATION

Date: ___________________

Last Name: _____________________ First: _________________________ M.I:____________

D.O.B:_____________AGE:_____SEX: ______MARITAL STATUS _____________

S.S #____________________________________HOME PHONE # (_____) ________-________

Address: ____

City: ______________________________ State: ____________________ Zip: _________________

Emergency Contact: _____________________ Emergency Phone #:________________________

(Nearest Relative Not living with you)

Relationship: ___________________________________

Name of Spouse, Patient or Guardian: ____

Their Mailing Address: ____

City, State, Zip: _____________________________________ Telephone#:____________________

WORK INFORMATION

Employer: __________________Address: ____

City: _______________ State: ___________________ Zip: ___________

Work Phone#____________________

IN CASE OF EMERGENCY CONTACT OR RESPONSIBLE FOR CHILDREN UNDER 18

Last Name: __________________________ First: ____________________________ M. I: _________

Address: ____

City: _______________________ State: __________________ Zip: ________________________

Phone Number: _______________________ Relationship to Patient: ______________________

INSURANCE INFORMATION

Primary Insurance: ___________________________Phone#___________________

Insurance Address: ____

City:_______________ State:_______ Zip:______ Insurance Phone______________

Policy Holder Name: _______________________________Birth Date: ___________

Guarantor Address: _______________________________ S.S #:________________

Relationship: _______________Group#:______________Policy/ID#:________________

Guarantor Employer: _________________________ Guarantor Phone: _____________

I CONSENT FOR TREATMENT

I HEREBY AUTHORIZE THE PHYSICIANS AT FAMILY MEDICAL CARE, LTD, MEDICAL STAFF, UNDER THEIR DIRECTION, TO CONDUCT SUCH EXAMINCATION, ADMINSTER TREATMENT AND MEDICATION AS THEY DEEM NECESSARY OR ADVISABLE. I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO FAMILY MEDICAL CARE, LTD SHOULD THE EXCEPTIONAL CIRCUMSTANCE ARISE WHERE INSURANCE IS ACCEPTED. I HEREBY AUTHORIZE THE RELEASE OF INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO MY FAMILY OR INSURANCE COMPANY

Date: _______________________ Signature: _______________________________

ACKNOWLEDGMENT OF RECEIPT OR KNOWLEDGE OF FAMILY MEDICAL CARE LTD PRIVACY NOTICE

I, ____ acknowledge that I have either been given or have been made awareness of **FAMILY MEDICAL CARE LTD,** “Notice of Privacy Practice”. I have had full opportunity to read and consider the contents of this Notice of Privacy Practices.

Signature: ________________________________ Date: _________________________

If you signed this receipt as a personal representative on behalf of the individual, complete the following:

Personal Representative’s Name: ____

Relationship to Individual: ____________________________________

Date of Birth of Patient: ______________________________________

I give authorization to the following people to receive my protected health/medical information.

Name:__________________________________ Relationship:___________________________

Name:__________________________________ Relationship:___________________________