Tupelo Medical Group
Tupelo, Mississippi

PATIENT INFORMATION SHEET

Acct Number ____________

Patient Information

Your Doctor ____________ Referring Doctor ____________

Last Name ____________ First Name ____________ Middle ____________ Preferred/Nickname ____________

Maiden Name ____________ Circle Mr. Ms. Mrs. Miss Date of Birth ____________ Sex ____________ Social Security # ____________

RACE:
- __White
- __Black/African American
- __American Indian/Alaska Native
- __Asian
- __Native Hawaiian/Pacific Islander
- __Multiracial

Marital Status ____________ Drivers License ____________ Emergency Contact ____________ Phone # ____________

ETHNICITY: ____Hispanic ____Non Hispanic LANGUAGE: ____English ____Spanish ____Japanese ____Other

Address Information

Address ____________ City/State/Zip ____________ County ____________

Phones

Home ____________ Work ____________ Cell ____________ Fax ____________ Preferred Phone # ____________

Email Address ____________

Please Circle Preferred Method of Contact: Home Work Cell Email

Other Information

Employer Name ____________ Status ____________ Occupation ____________ Phone/Ext ____________ Hire Date ____________

Address ____________

Insurance Information (please give card to receptionist)

Primary Insurance Carrier (including Medicare)

Insurance Company ____________ Policy Number ____________ Group Number ____________

Policy Holder's Name ____________ Employer ____________ Social Security # ____________ Date of Birth ____________

Effective Dates: ____________ Start Date ____________ End Date ____________ Relationship to Patient ____________ Phone ____________

Secondary Insurance Carrier (please give card to receptionist)

Insurance Company ____________ Policy Number ____________ Group Number ____________

Policy Holder's Name ____________ Employer ____________ Social Security # ____________ Date of Birth ____________

Effective Dates: ____________ Start Date ____________ End Date ____________ Relationship to Patient ____________ Phone ____________

For TMG Use Only
HIPAA ____
Consent ____

Signature ____________ Date ____________

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TUPELO MEDICAL GROUP

CONSENT FOR RELEASE OF INFORMATION TO CAREGIVER

I consent for Tupelo Medical Group to disclose any and all of my protected health information (PHI) concerning my medical treatment or care including but not limited to laboratory and other test results, immunizations, x-rays, appointments, referrals to other physicians, medications, diagnoses and prognoses to the following caregivers:

Name ______________________________ Relationship ____________ Phone # __________________

Name ______________________________ Relationship ____________ Phone # __________________

Name ______________________________ Relationship ____________ Phone # __________________

Name ______________________________ Relationship ____________ Phone # __________________

I understand that it is my responsibility to notify Tupelo Medical Group of any changes in the above information. If changes do occur, I understand that I must file **in writing** another Consent for Release of Information to Caregiver.

I understand that this consent only authorizes VERBAL communication and to **sign to pick up written prescriptions.**

A written authorization from me or my authorized personal representative is required to release any of my protected health information in writing to any of the caregivers listed above.

I understand that I may revoke this consent at any time by submitting a written revocation except to the extent that action has been taken by Tupelo Medical Group in reliance on my consent.

This Consent for Release of Information to Caregiver will remain in full force and effect unless changed or revoked by me in writing.

______________________________ Date of Birth__________________
Printed Name

______________________________ Date Signed__________________
Signature of Patient/Patient Representative

TO BE COMPLETED ONLY IF SIGNED BY PATIENT REPRESENTATIVE

Printed Name of Patient's Representative ______________________________

Description of Representative's Authority to Act for Patient:

____

Relationship to the Patient: ____

Signature of Witness: ______________________________

TUPELO MEDICAL GROUP – 1265 CLIFF GOOKIN – TUPELO MS 38801 (662) 840-2131 – FAX (662) 840-2522

GENERAL CONSENT FORM

Name: ______________________ MR # ________________ SS# ________________
DOB ________________ Acct # ________________

I, the undersigned, agree to the following:

CONSENT FOR MEDICAL TREATMENT
I hereby voluntarily consent for care encompassing diagnostic procedures and treatment by my physician/nurse practitioner, his assistant, designees or consultants, as may be necessary in the judgement of my physician/nurse practitioner. I also understand that I will be billed direct for those services provided. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the result of the treatment or examination at Tupelo Medical Group (hereinafter referred to as TMG). I understand that my medical record may be maintained on a computer-based system and authorize access to persons involved in my care. I authorize TMG to submit my prescriptions electronically and to access my prescription medication history through the electronic pharmacy network.

RELEASE FROM RESPONSIBLIITY FOR LOSS OF VALUABLES
TMG is not responsible for valuables, including money, jewelry, glasses, dentures, documents and other personal items.

RELEASE FROM RESPONSIBILITY
If I should leave TMG against medical advice or prior to treatment being completed, I hereby relieve the physician/nurse practitioner and TMG of all liability for my action.

AUTHORIZATION FOR RELEASE AND USE OF MEDICAL INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS
I authorize TMG or TMG's designee to disclose to payors including, but not limited to, insurers, workers' compensation carriers, the Centers for Medicare and Medicaid Services, or any other parties that may be liable for all or part of TMG's charges ("Third Party Payors"), all or part of my medical records as may be necessary to process payments for health care services provided. I authorize these payors to pay directly to TMG. I also authorize TMG to utilize my medical information, or to release all or part of my medical information to other health care providers consulted by my physician/nurse practitioner or TMG, as may be necessary. I understand that TMG will take actions in reliance on this authorization to release medical information and that this information will be released only as necessary to carry out treatment, payment or TMG operations.

NOTICE OF PRIVACY PRACTICES
I acknowledge that I have been given a copy of TMG's Notice of Privacy Practices. My initials acknowledge receipt of a copy. I understand that TMG reserves the right to change the terms of its notice provisions and that I can obtain from TMG any revisions to this privacy policy.

MEDICARE CERTIFICATION RELEASE
I certify that the information provided to TMG in requesting payment under Title XVIII and Title XIX of the Social Security Act is correct.

NON-CERTIFICATION OF SERVICES
I hereby agree that as the policyholder or patient, I share the responsibility of assuring certification is obtained from the insurance company on the above party for any services indicated. If certification is not obtained, I further agree that in the event the insurance company denies either all or part of their payment to TMG, I will pay the account in full upon demand.

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ASSIGNMENT OF BENEFITS

I hereby assign to TMG, or its duly authorized agents and/or assigns, all rights, benefits, and interests in all proceeds from all Third-Party Payors. I request that payment of authorized Medicare and Medigap benefits be made on my behalf to TMG for any services furnished to me by TMG. I further authorize TMG to take all necessary actions to ensure that any insurance benefits otherwise payable to me, or my estate, are paid directly to TMG. This authorization includes, but is not limited to, billing insurance, filing petitions, filing suit in name or on behalf of TMG, filing proofs of claim, filing probate claims and filing grievances and all other similar procedures. I agree to provide and sign any other documents that may be reasonably necessary to accomplish any of the above purposes. I understand that any amount paid in excess of regular charges will be refunded as appropriate to the Third-Party Payor, the patient, or guarantor.

FINANCIAL RESPONSIBILITY AGREEMENT

I understand that my insurance policy is an agreement between me and my insurance company to pay a certain amount for medical care. I understand that my physician/nurse practitioner's bill is an agreement between me and them and that I am responsible for full payment for medical services that are provided to me, regardless of the status of my insurance claim. If my insurance claim is not paid in full by my insurance company within 60 days from the filing date, the entire amount of my bill will be due from me. I further agree that if my account should require action by a collection agency or attorney to ensure payment, I will pay a collection fee of up to 35% of the unpaid debt. This amount will be added to the balance due and unpaid on my account.

I understand that it my responsibility to ensure that my physician/nurse practitioner is a network provider with my insurance company and to determine if my insurance covers evaluation and treatment by a nurse practitioner.

CONSENT TO PHOTOGRAPH, VIDEOTAPE OR OTHER IMAGING

I authorize TMG to photograph or digitally image me as appropriate for medical record identification purposes and/or to document my medical condition. I understand that these images will be stored in a secure manner. Images that identify the patient will be released and/or used outside TMG only upon written authorization from me or authorized part or as assigned by law. I release, TMG, its physicians/nurse practitioners, employees and agent from any liability in the making and use of these requested photographs or digital images.

I have read the above consent and various releases, assignment of benefits and agreement for payment of charges and herewith execute the same voluntarily. A copy of this document will be valid as the original.

____

Printed Name

____ Date __________________

Patient Signature (or Person Responsible and Relationship

PATIENT IS UNABLE TO CONSENT BECAUSE __________________________________

Witness ______________________________ Date __________________