Webb Family
MEDICAL CLINIC
Your Hometown Doctor!

Medical Form

Patient Information

Patient's Full Name _____ Date of Birth _____

Patient's Mailing Address _____

City _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Social Security # _____ Gender (Circle One): Female Male

Marital Status (Circle One): Single Married Divorced Widowed

Employment Status (Circle One): Employed Retired Disabled Student

Employer: _____ Employer Phone: _____

Financial Responsibility (Circle One) Self Other

*** If under 18*** Parent/Guardian's Name: _____

Relationship to Patient: _____ Phone Number: _____

Address: _____

Primary Insurance: _____ Policy #: _____

Name on Card: _____ DOB: _____

Secondary Insurance: _____ Policy #: _____

Name on Card: _____ DOB: _____

Local Pharmacy: _____

Emergency Contact & Phone Number: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the clinic. I understand that I am financially responsible for any patient balance. I also authorize Webb Family Medical Clinic, PLLC and associated companies to release any information needed to contact me by phone or email.

Signature: _____ Date: _____

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Authorization to Release Medical Information to Family Member(s), Guardian, and Others.

Parent Information

Patient First and Last Name: _____

Date of Birth: _____

I hereby authorize medical providers and personnel of Webb Family Medical Clinic to discuss and/or release my protected health information with: (Please note that fi the patient is a minor, each parent/guardian needs to be listed.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that such revocation is not effective to the extent that the Clinic has relied on the use or disclosure of protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization.
Family Medical Clinic to discuss and/or release my protected health information with: (Please note that fi the patient is a minor, each parent/guardian needs to be listed.)

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient of Personal Representative Relationship to Patient

Patient Authorizations and Assignments

Consent for Treatments

I have requested professional services from Webb Family Medical Clinic, PLC on behalf of myself, and understand that by making this request, I become fully financially responsible for any and all charges incurred the course of the treatment authorized. I acknowledge that I may request special payment arrangements based on my ability to pay amounts that are not paid by my insurance to include financial hardship discount.

Assignment of Benefits

I hereby assign all medical benefits and payments toWebb Family Medical Clinic, PLLC. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment checks) directly to Webb Family Medical Clinic, PLLC rendered to myself regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

Thereby authorize Webb Family Medical Clinic, PLLC to (1) Release any information necessary ot insurance carriers or payers regarding my illness, diagnosis, and treatments; (2) Process insurance claims generated in the course of examination or treatments; (3) Allow photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order wil remain in effect until revoked by myself in writing. I authorize and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original.

HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Webb Family Medical Clinic, PLLC to use and disclose my protected health information to carry out (1) treatment (including direct or in direct treatment by other healthcare providers involved in my treatment) (2) obtaining payment from third party payers (e.g., my insurance company) (3) the day. to-day healthcare operations of Webb Family Medical Clinic, PLLC.

I have also been informed of and given the right to review and secure a copy ofWebb Family Medical Clinic's Notice of Privacy Practice, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Webb Family Medical Clinic, PLC reserves the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, pay the health care operation, but that you not required to agree to these requested restrictions. However, fi you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signature: _____ Date: _____