Patient Name: _____ DOB: _____ Date: _____

# EPIC Medical Clinic

**Patient's Name**: _____

Date of Birth: _____/_____ /_____ Sex: Male _____ Female _____

Address: _____

_____

Email: _____

Cell Phone: ( ) _____ Alternate Phone: ( ) _____

Marital Status: Single _____ Married_____ Other (specify) _____

## Spouse/Significant other or Guardian information

Name: _____ Date of Birth: _____/_____/_____

Address: _____

Contact number: ( ) _____ Email: _____

## Insurance Information

Primary Insurance Company: _____

Relationship to the insured person: Self_____ Spouse_____ Child_____ Other_____

Name of the primary person insured: _____

ID Number: _____ Group Number: _____

Customer Service Contact Number: ( ) _____

## Emergency Contact Person

Name: _____ Phone Number: ( ) _____

## How did you hear about us?

Friend or Family_____ Online/Internet_____ Drive by_____ Other_____

**Patient or Parent/Guardian Signature**: _____

**Print Name:** _____ **Date:** ____/_____/_____

Patient Name: _____ DOB: _____ Date: _____

# EPIC Medical Clinic

## Medical History:

Please indicate if you have experienced any of the following medical conditions.

___ High Blood Pressure ___ Diabetes ___ High Cholesterol ___ Stroke

___ Thyroid disorder ___ Anemia ___ Heart disease ___ Blood Clots

___ Kidney problems ___ Arthritis ___ Cancer ___ Skin Disorder

Other (specify): _____

**Allergies:** (Please indicate in writing if you have any allergies to medications, food, or vaccines, etc).

**____ None** _____ _____

**Medications:** (List your prescription & over-the-counter medications including dosage instructions).

_____ _____ _____

_____ _____ _____

## Family History:

(Please indicate in writing if there is any history of High Blood Pressure, Diabetes, Heart Disease or other medical problems in your family).

_____

_____

## Social History:

Smoking ( ) Yes ( ) No Alcohol use ( ) Yes ( ) No Drug or Substance abuse ( ) Yes ( ) No

**Patient or Parent/Guardian Signature**: _____

**Print Name:** _____ **Date:** ____/_____/_____

# EPIC Medical Clinic

## CONSENT FOR MEDICAL TREATMENT

I present to EPIC Medical Clinic and consent to treatment of the medical provider on duty and whomever they may designate as their assistant, associate and patient care staff. Such care may include, but is not limited to, diagnostic tests and procedures, and administration of medications considered advisable in my course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations, and I understand that all medical treatments contain inherent risks.

## ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE

In consideration of services provided, I hereby assign and transfer to Legend Medical Clinic any and all rights, which I have against insurance companies or third party payers, for payment of charges for services provided by EPIC Medical Clinic to me or to one of my dependents. I authorize said payments to be applied to any unpaid balance for which I am responsible.

I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies or third party payers. I agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with EPIC Medical Clinic. It is our policy that any insurance co-pays and deductibles or any balance of a bill owed by those without insurance is due at the time of service.

## RELEASE OF PATIENT INFORMATION

I authorize the release of my medical records, financial transactions, and health information to:

1. Medical providers on staff at EPIC Medical Clinic, agents of another healthcare facility if transfer to another facility is required, workers compensation carriers, to my primary care physician or any referred consultants for follow up or continued care.
2. Insurance company or other third party payer and their agents as well as any review organization or government agency for the purpose of determining eligibility and availability of benefits, obtaining payment for services provided, and insuring government compliance.
3. Educational or scientific institutions, on anonymous basis, any information concerning my care, which is necessary or appropriate for the advancement of medical science and research as authorized by law. The patient agrees that in all instances, the original medical records remain the property of EPIC Medical Clinic.

**Patient or Parent/Guardian Signature**:_____

**Print Name:** _____ **Date:** ____/_____/_____

# EPIC Medical Clinic

## AUTHORIZATION TO RELEASE MEDICAL & HEALTH RELATED INFORMATION

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act (HIPAA) of 1996, in order for your medical provider or the staff at EPIC Medical Clinic to give copies of and/or discuss your medical & health related information with members of your family or other individuals that you designate other than your primary care doctor of specialist, we must obtain your prior authorization.

In the event that you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

**I authorize EPIC Medical Clinic to release any and all of my medical and/or health related information to the following individuals:**

Name: _____ Relationship: _____ Phone No: _____

Name: _____ Relationship: _____ Phone No: _____

**May we leave a message on your voicemail or answering machine at the phone number provided?**

( ) Yes ( ) No

If you choose to answer No, then you agree to assume full responsibility for contacting EPIC Medical Clinic for the results of all testing and care plan.

## RECEIPT OF HIPAA PRIVACY NOTICE

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how EPIC Medical Clinic may use and disclose my protected health information. I understand that EPIC Medical Clinic reserves the right to change the privacy notice.

**Signature of Patient or Parent/Guardian:** _____

**Print Name:** _____ **Date:** ___/___/_____