PRIMARY MEDICAL

Registration, Consent to Treatment, and Authorization to Release Medical Information

Monoclonal Antibody Clinic

Last Name: ____________________ First Name: ____________________ Middle Name/Suffix: ______________

Legal Sex: M / F Date of Birth: __________________

Address: ____

City: ____________________ State: __________ Zip: _______________ Country: _________________________

Patient's Email: _______________________________________

Home Number: __________________________ Mobile Number: ______________________________

Primary Care Physician: _________________________ Referred By:__________________________

Demographics

Primary Language (English/Spanish/etc): ____

Race: _____________________________________ Ethnicity: ___________________________________

Marital Status: ____________________

Emergency Contact

Name: ____ Relationship: ______________________________

Home Phone: _____________________________ Mobile Phone: _____________________________

Primary Insurance: ____

Subscriber Name: ____________________________________ Date of Birth: ________________________________

Member ID number: __________________________________ Subscriber relationship to Patient: ________________

Secondary Insurance: ____

Subscriber Name: ____________________________________ Date of Birth: ___________________________

Member ID number: _________________________________ Subscriber relationship to Patient: ________________

Consent for Treatment: I hereby consent to and authorize the administration of all treatments that may be considered advisable or necessary in the judgment of any physician who examines and treats me. If at any time I disagree with the treatment plan, I may decline against medical advice. You are authorized to furnish a copy of this report to my insurance carrier. **Authorization and Assignment**: I hereby authorize agents of Primary Medical Group to furnish information to any and all medical records concerning my care to physicians, hospital or other healthcare professionals providing care to me at any time. I authorize agents of Primary Medical to obtain my prescription medication history from other health care providers or pharmacies. Additionally I authorize Primary Medical to release any and all medical records concerning my care to Medicare, any insurance carriers, 3rd party review organization carriers or managed care companies concerning my illness and treatments and I hereby assign to the doctor all payments for medical services rendered**.**

____ ________________________________

Signature of Patient/Responsible party Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of Primary Medical to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

Check one please:

_____ I do not authorize Primary Medical to release any or all information concerning my medical care to any individual except as set forth above.

_____ I authorize Primary Medical to verbally release any and all information concerning my medical care to the following individual(s):

Name: ___________________________________ Name: ___________________________________

Relationship to Patient: ______________________ Relationship to Patient: ______________________

____ ________________________________

Signature of Patient/Responsible party Date