Batish Family Medicine

Outpatient Information / Consent to Treat

PATIENT NFORMATION	Account#	Medical Record #	Date
Patient Name		Referring Doctor	
Address		Referring Doctor Phone #	
City/State/Zip		Email address	
(H) Phone # (C)	Work Phone	Employer/School	
Social Security #	Date of Birth	Age / Marital Status / Sex	
Emergency Contact	Relationship	(H) Phone # (C)	
Responsible Party	Relationship	DOB / SS#	
Responsible Party Address		City/State/Zip	Phone #
INSURANCE INFORMATION			
Primary Insurance	Employer	Secondary Insurance	Employer
Insurance ID #	Insurance Group #	Insurance ID #	Insurance Group #
Insured Name		Insured Name	
Address		Address	
City/State/Zip		City/State/Zip	
Insured DOB	Insured SS #	Insured Name	Insured SS #

Financial Responsibility and Assignment of Insurance Benefits

I guarantee payment to Batish Family Medicine of all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits, which would otherwise be payable to me, to Batish Family Medicine for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct.

Consent for Healthcare and Release of Medical Information

I voluntarily consent to healthcare treatment ('Treatment') from the physicians and staff at Batish Family Medicine. I consent to any necessary lab work, including HIV testing. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the results of treatments or examinations by my caregivers. I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations. I have read this form. I have had the opportunity to ask questions and my questions have been answered.

Signature of Patient or Authorized Person	Date/Time
Insured Party or Financial Guarantor (if different from above)	Date/Time

Acknowledgement of receipt of Joint Notice of Privacy Practices

I have received a copy of the Batish Family Medicine Joint Notice of Privacy Practices. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice on Batish Family Medicine's website at www.batishfamilymedicine.com or by contacting the office.

Signature of Patient or Authorized Person	Date/Time

For Staff use only

❑ Patient refused to sign after he/she received Joint Notice of Privacy Practices and was informed that signing the form merely acknowledges that the patient actually received the notice.

❑ Patient was initially treated for an emergency condition. Patient either was given the Notice after stabilization or will be given the Notice after transfer. (Circle one)

Signature of Staff	Date/Time

If limited English proficient or hearing impaired, offer interpreter at no extra cost:

❑ Interpreter accepted_____ ❑ Interpreter refused

(Name/Number of Person/Services Chosen/Used)