PLEASE COMPLETE ALL AREAS MARKED WITH AN *ASTERISK*

Batish Family Medicine — Outpatient Information / Consent to Treat

PATIENT INFORMATION

Account #			Medical Record #			*Date	
*Patient name			Referring Doctor				
*Address			Referring Doctor Phone #				
*City/State/Zip			*Email Address				
*Primary Phone #	*Work Phone #		*Employer/School				
*Social Security #	*Date of Birth		*Age	*Race	*Marital Status		*Sex
*Emergency Contact	*Relationship		*Primary Phone #				
*Responsible Party	*Relationship		*Date of Birth			*Social Security #	
*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 DOB	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**
Insured Party or Financial Guarantor (if different from above)	Date

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**

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

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

☐ Interpreter accepted _____ ☐ Interpreter refused

Name/Number of Person/Services Chosen/Used