OLNEY MEDICAL GROUP
INFORMATION UPDATE FORM
** Fill the information you intend to be updated in your records

Last name: ______________________________ First name: ____________________________MI:______________

DOB: ________/__________/________________ Sex: M ☐, F ☐

CHANGE IN ADDRESS:
Street address:____

City: _____________________________________State:___________________________Zipcode:______________

CHANGE IN PHONE NUMBER(S):
Cell Phone: (_______)________________________ Home/Work Phone: (_______)_________________________

Email: ____ SSN:_______________________________

CHANGE IN INSURANCE INFORMATION:
Insurance name: ___________________________________ID:____________________________ NO Insurance ☐

Group: ___________________________________Provider Phone Number :________________________________

PRIVACY PRACTICES ACKNOWLEDGEMENT

A. I have read the notice of privacy practices and I have been provided an opportunity to receive it.

B. **Assignment of insurance benefits:** I hereby direct payment of surgical medical benefits to **OLNEY MEDICAL GROUP** for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

C. **Authorization to release information:** I hereby authorize **OLNEY MEDICAL GROUP** to release any medical care or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

D. **Medical record policy**: I hereby authorize **OLNEY MEDICAL GROUP** to release my medical record to: ______________________________________ Relationship: ____

E. **Insurance card and ID policy**: I understand that I must bring a physical insurance card and a current form of ID to every appointment. Without both physically present, I may be asked to reschedule my appointment. Picture of the insurance card or photo ID on your phone will not be accepted. Nor can we accept for copies to be emailed to the office, as that is a violation of HIPAA Regulations.

F. **Controlled pain medication/sleep medicine policy**: I understand that this office does **NOT** refill chronic pain and sleep medications. If needed, the office will give me a referral for pain management or psychiatrist.

Patient’s Signature : _________________________________ Date:_________________________________