☐ 8421 W Broadway Ave
Brooklyn Park, MN 55445
Tel: (763) 292-5096
Fax: (763) 292-5097

ASSURED HEALTH

☐ 3333 W Division St, Suite 110
St. Cloud, MN 56301
Tel: (320) 774-2599
Fax: (763) 292-5097

PATIENT INFORMATION

Patient Name:_____Birthdate:_____
Last First Middle

Address:_____ Email:_____

City:_____ State:_____ Zip:_____

Cell Phone:_____ SSN (optional) _____-_____-_____

Sex: ◯ Male / ◯ Female Marital Status: ◯ Single / ◯ Married / ◯ Widowed / ◯ Separated / ◯ Divorced / ◯ Other

Consent to Call: ◯YES / ◯ NO Consent to Text: ◯YES / ◯ NO Consent to Profile Picture: ◯YES / ◯ NO

Emergency Contact Person:_____Relationship:_____Phone:_____

ASSIGNMENT AND RELEASE

I, undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Assured Health LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X_____ _____ _____
Responsible Party Signature Relationship to Patient Date

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with MN State Law the Privacy Rule if the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I understand that:

1. ASSURED HEALTH, LLC uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized by ASSURED HEALTH, LLC.
2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to ASSURED HEALTH, LLC.
3. I have the right to revoke this authorization at any time by writing to ASSURED HEALTH, LLC. I understand that I may revoke this authorization except to the extent that action has already been taken based on this information.
4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this discloser
5. Information disclosed under this authorization might me re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
6. This authorization expires one year from the date of my signature below.
7. THIS AUTHORIZATION DOES NOT ATHORIZE ASSURED HEALTH LLC TO DISCUSS MY HEALTH INFORMATION OR MEDICAL WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

X_____ _____ _____
Responsible Party Signature Relationship to Patient Date

FOR OFFICE USE ONLY: SCAN DATE_____

□ DOT □ WALK-IN □ IND SUB □ IMMUNIZATION

□ PCP □ PHYSICAL □ MAIN SUB □ DX TEST