Access Quality Healthcare

Authorization/Release Form

Last Name: ____________________________ First Name: ___________________

Medical Records Release/Benefits Consent/ Signature on File

I authorize payment to be made directly to Access Quality Healthcare. I permit a copy of this consent to be used in place of the original.

Insurance Coverage/Assignment of Benefits/ Signature on File

We are an Occupational healthcare practice; therefore, we need you to be aware, that we **DO NOT** bill any private health insurance, and we are **NOT** a participating provider of **MEDICARE & MEDICAID.** Any services provided that do not fall under the category of a Workers Comp claim, Auto accident claim or Employer authorized visit will be billed to you as a self-pay service. After payment to our office you may submit any self-pay services to your private health insurance for possible reimbursement. You **MAY NOT,** however submit any bills for any type of reimbursement to **MEDICARE OR MEDICAID.**

In the event you have no insurance coverage which will pay for treatment at this office you assume full responsibility for payment. If you provide Insurance information, then you certify that the insurance(s) reported herein for this visit/service is a complete listing. I understand that failure to disclose insurance information will result in me being held personally liable. **I hereby authorize payment directly to Access Quality Healthcare for the office visit(s)/service(s) as well as acknowledge that I have read/received a copy of the Billing Policy.**

Initial: ___________

Payment Policy

Any services you are paying out of pocket for whatever reason must be paid at the time of service, NO exception. All payments are expected to be made in U.S. dollars. AQH accepts Visa, MasterCard, American Express, and Discover.

Consent for Treatment and release of Medical Records / Signature on File

I consent to treatment within Access Quality Healthcare and affiliated entities. I grant permission to the physicians, employees and other persons authorized by Access Quality Healthcare to render routine medical care that includes, but is not limited to diagnostic procedures and medical treatment, and to carry out all orders deemed advisable by my attending or treating physician. I understand that no guarantee or assurance has been made as to the results that may be obtained. I understand that some physicians providing care to me may not be employees or agents of this practice.

I hereby consent to the use and disclosure of my health information for treatment, payment and health care operations as described in Access Quality Healthcare's Notice of Privacy Practices.

Acknowledgement of Receipt of Privacy Notice

I hereby acknowledge that I have read/received a copy of Access Quality Healthcare's Notice of Privacy Practices.

Patient/Authorized Signature: _________________________________**Date:** ___________

I am verifying that all of the information given above is correct at the present time and understand that I am responsible for all charges regardless of Insurance status as well as any cost for collection should such action become necessary.

6 mos. Periodic review: Initials/Date: _________ /______________

Welcome

Access Quality Healthcare

NEW PATIENT REGISTRATION FORM

Patient Information:

Last Name:_______________________________ First Name:_________________________ Mid. Int._____ ☐ Male ☐ Female

Date of Birth:_________________________ Social Security Number:_________________________

Address: ____ City: _______________________ State: _______ Zip:___________

Best phone number to be reached at :(____)________________ Other Number:(_____)__________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Name of Employer: ____Work #:( ) __________________

Name of Pharmacy : __________________________________, Location:_________________________

Name of Primary Care Physician: ______________________________________ Phone #_________________________

Emergency Contact: __________________________________ Phone:(____) __________________ Relationship:______________

Email Address: ____

Who referred you to our office?: ____

Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name:____

Address:____ City:_________________________ State:______
Zip:_____________

Home Phone: __(____)_____________________ Cell Phone: _(____)___________________ Work Phone:_(____)____________

Please see reverse side for authorization and consent information as well as signature line.