Hope Internal Medicine Clinic
525 Shiloh Rd Ste 4100
Plano, Tx 75074
469-613-1948

Name:_____ DOB:_____

SSN:_____ Legal Sex: Male Female Marital Status:_____

Spouse/Guarantor Name:_____Spouse/Guarantor DOB:_____

Primary Phone #:_____ Alt Phone #:_____

Address:_____

City:_____ State:_____ Zip:_____

Occupation:_____ Employer:_____

Preferred Pharmacy:_____

Emergency Contact Name and Number:_____

List of names of people we have permission to speak with on your behalf :_____

_____

Yes/No You have my permission to leave voice messages concerning my health and account information
Yes/No You have my permission to obtain medical information via electronic media
Yes/No You have my persmission to speak with my employer,insurance company, or other agent regarding any difficulties in processing insurance claims

_____ Date:_____
Signature of Patient or Legal Representative

PLEASE ALSO READ AND SIGN BACK OF THIS PAGE

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CONSENT TO TREAT

I authorize Hope Internal Medicine Clinic (Hope IMC) and/or authorized persons employed by them to perform and/or initiate medical evaluation and treatment, and to authorize or order services on my behalf.

RELEASE OF INFORMATION

I authorize Hope IMC to release any information to any physician,hospital and or insurane company involved in my care including records of any treatments or exams rendered during period of such care.

ASSIGNMENT OF BENEFITS

I authorize and request payments of insurance directly to Hope IMC. I agree to provide current and valid insurance information to Hope IMC for such processing.

FINANCIAL AGREEMENT

Payment for service is due at the time services are rendered unless other arrangements have been made in advance. This includes co-pays, deductible, co-ins remainders, previous balances, and full cost of visit for private pay patients. If I have not provided correct and valid insurance for dates of service, I agree to pay for care.

PRIVACY PRACTICES

I understand that Hope IMC may use and disclose my health information in order to:

1. Make decisions about and plan for my care and treatment
2. Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
3. Submit bills,claims, and other related information to insurance companies or others who may be responsible to pay for some or all of health care

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand this this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy.

_____ Date:_____

Signature of Patient or Legal Representative