



PATIENT AGREEMENT AND SIGNATURE PAGE

BILLING AUTHORIZATION AND ASSIGNMENT OF BENEFITS

- 1. I hereby authorize Yanceyville Primary Care to furnish information to insurance carriers concerning my diagnoses and treatments. My signature on this document authorizes my provider to submit claims for benefits, for services rendered or for services to be rendered
2. I request payment of authorized Medicare benefits, or other health insurance benefits, be made either to me or on my behalf directly to Yanceyville Primary Care. Insurance authorization and assignments of benefits are effective until revoked.

DEEMED CONSENT TO TESTING

- 1. I authorize Yanceyville Primary Care to test for HIV antibodies, Hepatitis, or tuberculosis only if/when the provider or employees are exposed to my body fluids in a manner in which HIV or tuberculosis may be transmitted.
2. In the event of such an exposure, I consent to the release of the test results to the person(s) who were exposed.

AUTHORIZATION FOR TREATMENT

- 1. I, the undersigned, consent to the performance of medical or surgical procedures including, but not limited to, medical examinations, immunizations, therapeutic injections, invasive or surgical procedures and other medically appropriate services advised by Yanceyville Primary Care and mutually agreed upon for the patient named on this form.
2. This does not negate any existing living wills or and this consent may be revoked at any time.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

- 1. Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by mail or in person. By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations as stated in our Privacy Practices.
2. The undersigned as the patient or the patient's personal representative has received a copy of the "Yanceyville Primary Care Privacy Policy Document," has read and understands its content and accepts its terms. If the acknowledgement of receipt is not obtained (i.e. emergency treatment situation) the hospital representative (witness) must document his/her good faith efforts to obtain the reason why the acknowledgement was not obtained.

ACKNOWLEDGEMENT OF FINANCIAL POLICIES

- 1. I agree to abide by the terms of the financial policy and accept responsibility for any balance not covered by my insurance company(s), if applicable.
2. If my account becomes delinquent, I agree to pay all costs incurred in collection the account, including any necessary collection and attorney fees.

We greatly appreciate your understanding of and cooperation with our office policies.

X _____
PRINT Name

IF PATIENT CANNOT OR REFUSES TO SIGN:

X _____
PATIENT /PARENT SIGNATURE Date

Printed Name Date /Time

Relationship to the patient:

Reason that pt could not /would not sign:

PATIENT NAME:		EMAIL:	
IN CASE OF EMERGENCY:			
Contact Name & relationship:			
Phone number:		<i>Alternate Number:</i>	
2 nd Contact Name & relationship:			
Phone number:		<i>Alternate Number:</i>	
MEDICAL HISTORY/PROBLEMS:			
SURGERY/OPERATIONS:			
MEDICATION ALLERGIES: (include what kind of reaction you have):			
FAMILY HISTORY: We are checking for the following diseases in your parents, brothers/sisters, children, or grandparents, or aunts/uncles			
	Which family member? What side of the family?		
Cancer (what kind? At what age?)			
Heart problems (at what age did it start?):			
Diabetes			
Stroke			
High Cholesterol			
High Blood Pressure			
ADULTS:		IF PATIENT IS A CHILD:	
DO YOU SMOKE? YES / NO Do you dip/chew tobacco? YES / NO If YES, how much? _____ At what' age did you start? _____		IS HE/SHE YOU AROUND ANY SECOND HAND SMOKE? <i>YES / NO</i>	
ARE YOU AROUND ANY SECOND HAND SMOKE? YES / NO		WHAT SCHOOL DOES HE/SHE GO TO? WHAT GRADE?	
HOW MUCH ALCOHOL DO YOU DRINK?		WHO LIVES IN THE HOME? (MOTHER, FATHER, BROTHER/SISTER, ETC)	
WORK HISTORY: Are you working now? ____ Yes. Type of work: _____ ____ No, I'm out of work. ____ I'm retired. ____ I've never been employed.			
MARITAL STATUS: Married Single In a relationship			
DO YOU HAVE CHILDREN (how many? how old are they?):			

PLEASE LIST YOUR MEDICATIONS AND ANY OVER-THE-COUNTER MEDICATIONS AND VITAMINS IF YOU DO NOT HAVE THEM WITH YOU TODAY: