PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **MI** _____

Address: _____ **Apt #:**_____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work:** _____ **Ext:** _____

Cell Phone: _____ **Birth Date:** _____ **Sex:** M F

Soc. Sec. #: _____ **Drivers License #:** _____ **State:** _____

Marital Status: Married Single Divorced Widowed

Who referred you to our office? _____

Employer: _____ **Occupation:**_____

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Nearest Friend/Relative Not Living With You:_____

Relationship _____ Phone: _____

SPOUSE OR RESPONSIBLE PERSON FOR MINOR:_____

Birth Date: _____ Soc. Sec. #: _____

Address: _____ City: _____ State: _____ Zip:_____

Employer: _____ Work Phone: _____

INSURANCE INFORMATION:

Insured: _____ **Relationship To Patient:** _____

Soc. Sec. # _____ **Birth Date:** _____

Insurance Company: _____ **ID#** _____

I understand that if any of the insurance I have provided is incorrect or if I fail to notify the office of any insurance changes, and/or additional coverage, that I am responsible for all physician charges.

I hereby authorize the release of any medical information necessary for the processing of insurance. I, hereby assign all medical and/or surgical benefits to which I am entitled to John Tenny, MD, PA. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Date: _____ **Patient or Legal Guardian Signature:** _____

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use of disclosure of my protected health information by John Tenny, MD for the purpose of diagnosing or providing treatment to me, prescribing medications through a pharmacy or pharmaceutical company, obtaining payment for my health care bills or to conduct health care operations of John Tenny, MD. I understand that diagnosis or treatment of me by Dr. Tenny may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used of disclosed to carry out treatment, payment or health care operations of the practice. Dr. Tenny is not required to agree to the restrictions that I may request. However, if Dr. Tenny agrees to the restrictions that I request, the restriction is binding on Dr. John Tenny.

I have the right to revoke this consent, in writing, at any time, except to the extent that John Tenny, MD has taken action in reliance of this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review John Tenny, MD's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the office of Dr. John Tenny. The Notice of Privacy practices for John Tenny, MD is also provided in each examination room where it is posted on the wall (If you would like a copy of The Notice of Privacy Practices, please ask the receptionist). This Notice of Privacy Practices also describes my rights and John Tenny, MD duties with respect to my protected health information.

John Tenny, MD reserves the right to change the privacy practices that are described in The Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Dr. John Tenny and requesting a revised copy to be sent in the mail or asking at the time of my next appointment.

_____

Signature of Patient or Personal Representative
"**By signing this document, I am stating I have read the Notice of Privacy Practices for this office".**

_____

Printed Name of Patient or Personal Representative

_____

Date

Texas State Law requires us to get your permission to release any medical information regarding your care, to anyone other than yourself or your medical insurance company. Please list below persons whom **you authorize us to release your medical information to:**

_____ _____

Name Relationship