

PATIENT INFORMATION

Date of Birth _____ / _____ / _____ Address _____

Last Name _____ Apt _____ Home Phone (____) _____ - _____

First Name _____ City _____ Cell Phone (____) _____ - _____

Middle Initial _____ State _____ Zip _____ Preferred Home Mobile/Work

Social Security # _____ - _____ - _____ Email _____

Sex M F

Emergency Contact Name _____ Phone _____ Relation _____

Patient Employed By _____ Work Phone _____

PARENT/GUARANTOR INFORMATION

Name (Last, First, Middle) _____

Date of Birth _____ / _____ / _____ Social Security # _____ Sex M F

Address _____ City _____ State _____ Zip _____

Home Phone _____ Mobile/Work Phone _____ Preferred Home Mobile/Work

Relationship to Patient Parent Guardian Spouse

PRIMARY INSURANCE

Carrier _____	Policy Holder Name _____
Member ID _____ Group # _____	Date of Birth _____ / _____ / _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F
Insurance Claims Address _____	Address _____
Phone _____	Relationship to Patient <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Spouse

SECONDARY INSURANCE

Carrier _____	Policy Holder Name _____
Member ID _____ Group # _____	Date of Birth _____ / _____ / _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F
Insurance Claims Address _____	Address _____
Phone _____	Relationship to Patient <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Spouse

AUTHORIZATION AND RELEASE

Authorization of Treatment: By signing this consent form, I voluntarily consent to the administration and cost of medical and surgical procedures, x-ray(s) and medication(s) for myself and my dependents.

____ Initial: **I understand Schertz-Cibolo Emergency Clinic is a Free Standing Emergency Facility, and is billed as an Emergency Room visit to my insurance carrier.**

Guarantee of Payment:

____ Initial: **SELF PAY:** I elect to pay for all services rendered in full today. I understand that my insurance will **NOT** be billed by Schertz-Cibolo Emergency Clinic.

____ Initial: **Assignment of Insurance Benefits:** By signing this consent form, I authorize payment directly to Schertz-Cibolo Emergency Clinic (SCEC) for all benefits other-wise payable to me. **I also acknowledge that SCEC will submit my bill to my insurance carrier as a courtesy; however, I am ultimately responsible for all charges incurred, unless both parties mutually agree otherwise.** I agree that I will pay my estimated balance based on the best available information of my current policy. I understand this is only an estimate. While SCEC makes every effort to verify my correct insurance information prior to leaving, I understand SCEC cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier.

Patient/Responsible Party Signature _____ Date _____

PRIVACY PRACTICES

Receipt of Privacy Practices: I acknowledge that a copy of the Notice of Privacy Practices of Schertz-Cibolo Emergency Clinic is available to me upon request and can be downloaded at www.schertzhealth.com. I understand that a copy of this consent form may be used with the same effectiveness as the original.

AUTHORIZATION OF RELEASE FORM

Release of Medical Records: By signing this form I authorize Schertz-Cibolo Emergency Clinic (SCEC) to release verbally, electronically, and/or in writing confidential medical information for purposes of treatment, payment of charges, quality assurance and utilization review, transfer and follow-up procedures to my insurance carrier, employer (if treatment is related to employment), other healthcare provider (s), and the following person (s).

Name: _____	Name: _____
Relation: _____	Relation: _____
Phone: _____	Phone: _____

I hereby authorize the release of my **COMPLETE** health record (including records relating to mental health care, communicable disease, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

- I hereby authorize the release of my **COMPLETE** health record **WITH EXCEPTION** of the following information:
- Mental health records
 - Communicable diseases (including HIV and AIDS)
 - Alcohol/drug abuse treatment
 - Financial Account information
 - Other (please specify): _____

OR

- I hereby authorize the release of following information:
- Records for dates of service from _____ to _____
 - Narrative reports Lab results Hospital records Pathology results
 - Radiology results

Patient Signature: _____ **Date:** _____

PATIENT RIGHTS

I acknowledge I have reviewed and received a copy of "Patient Rights and Responsibilities" from Shertz-Cibolo Emergency Clinic.

Patient Signature: _____ **Date:** _____

DISCLAIMER: All references to Schertz Cibolo Emergency Clinic include its physician group Schertz-Cibolo Emergency Physicians PLLC