WOODLANDS MEDICAL

## PATIENT INFO

Name: (LAST) (MI) (FIRST)

Address: (STREET) (CITY) (STATE) (ZIP)

Home Phone: Work Phone: Cell Phone:

Email Address:

DOB: / / Gender (circle one): M F Soc. Sec # : - -

Driver's License #: State:

Marital Status: S M W Spouse's Name:

Your Employer: Occupation:

Employer Address: (STREET) (CITY) (STATE) (ZIP)

Referred By: Primary Care Physician:

## INSURANCE INFORMATION

Insurance Type: Health Personal Pay PI/Auto Worker's Comp Medicare

Insurance Name:

Member #: Group #:

Insurer's Name (If Different From Patient): Relationship to Patient:

Insurer's DOB: / / Insurer's Soc. Sec #: - -

Insurer's Employer:

Person responsible for account:

**I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.**

**Patient or Parent/Guardian Signature** **Date:**

WOODLANDS MEDICAL

## Insurance Verification Disclosure/Agreement

As a courtesy, Woodlands Medical & Nobility Medical Group will verify and file my health insurance. However, verification of my insurance benefits does NOT guarantee payment for services rendered. As such, in the event of my health insurance non-payment or limitations, I am financially responsible for all charges incurred.

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Office Manager _____ Date _____

## View External Prescriptions Agreement

I authorize Woodland's Medical to view my external prescription history from the external source.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

My signature certifies that I read and understood the scope of my consent and that I authorize the access.

Patient name: _____

Patient signature: _____ Date: _____

# HIPAA Disclosure

## Standard Authorization of Use and Disclosure of Protected Health Information

### Information to Be Used or Disclosed

The information covered by this authorization includes:

All Patient Medical Records

### Persons Authorized to Use or Disclose Information to:

Name: _____

Information listed above will be used or disclosed by:

Woodlands Medical and/or Nobility Medical Group

### Expiration Date of Authorization

This authorization is effective through __12/2022__unless revoked or terminated by the patient or patient's personal representative.

### Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

I have read the above and hereby authorize _Woodlands Medical Office Manager_ to use my protected information for the listed reasons.

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Office Manager _____ Date _____

WOODLANDS MEDICAL

Dear Patient:

This office has joined Nobility Medical Group, PA, a multidisciplinary doctor group. We have done this for various reasons, with the most important one being that our facility can enjoy a more comprehensive approach to your health by utilizing an integrative health care model. This means the incorporation of Medical and Osteopathic physicians, who are directly involved in your healthcare, into our scope of various services. As such, certain services and diagnostics will be administered, when clinically warranted, and billed under the Nobility Medical Group, PA. As such, when you receive your explanation of benefits from your health insurance company, it will indicate the date of services and procedure codes and payments made to Nobility Medical Group, PA. If you have any questions regarding this exciting amendment to our office, please ask me.

Sincerely,

Jeremy D. Evans, DC
Jordan Pastorek, MD

WOODLANDS MEDICAL

# Release of Medical Records

I, _____, hereby authorize the release of my medical records

From:

_____

_____

_____

To:

Woodlands Medical

□ Mail to:

□ Fax to: 844-209-9082

_____
Print Name

_____
Signature

_____
Date of Birth

_____
Date


**ASSIGNMENT OF BENEFITS**

**Patient hereby irrevocably acknowledges full financial responsibility for all services provided to patient by Nobility Medical Group PA (Provider), as consideration for such Provider services. Patient irrevocably assigns to Nobility Medical Group PA (Provider), any and all benefits payable by or from any insurance or health care plan(s) coverage maintained by Patient as consideration for the total fee for those charges incurred by Patient as a result of those services rendered by Provider. Patient also assigns to Nobility Medical Group PA (Provider): (i) any and all benefits payable by or from any automobile medical payment coverage maintained by Patient or any party under whose policy of insurance Patient may have a lawful right of recovery, (ii) any and all benefits payable by or under any third party liability insurance coverage to which Patient may have a right of recovery due to the injuries for which Patient has sought Provider's health care services, and (iii) a "common law lien interest" in, and all contractual rights and claims to, any and all future insurance proceeds Patient has against any insurance company, health care benefit plan, or any other party contractually liable to Patient for payment of all or any portion of the health care services rendered by Nobility Medical Group PA (Provider), and the resultant charges therefore, to the Patient as a result of the injuries sustained by Patient. This irrevocable Assignment of Benefits, conveyance of lien interest and contractual rights to and for those charges attributable to Nobility Medical Group PA's (Provider) health care services shall extend to, but not be limited to, Provider's entitlement to any and all insurance proceeds remitted as a result of any insurance claim for damages by the Patient which has given rise to the above referenced health care services provider by Nobility Medical Group PA (Provider).**

**By my signature be it known that I have read and fully understand the above contract.**

**Patient Signature _____(Print)_____**

**Custodian Parent/Legal Guardian_____(Print)_____**

**Witness_____(Print)_____**

**Date_____**