SCHERTZ CIBOLO EMERGENCY CLINIC

How did you hear about us?
(PLEASE CIRCLE)
Web Word of Mouth Drive By HEB Mailer

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 _____

Member ID _____ Group # _____

Insurance Claims Address _____

Phone _____

Policy Holder Name _____

Date of Birth _____ /_____ /_____ Sex ☐M ☐F

Address _____

Relationship to Patient ☐Parent ☐Guardian ☐Spouse

SECONDARY INSURANCE

Carrier _____

Member ID _____ Group # _____

Insurance Claims Address _____

Phone _____

Policy Holder Name _____

Date of Birth _____ /_____ /_____ Sex ☐M ☐F

Address _____

Relationship to Patient ☐Parent ☐Guardian ☐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 _____

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EMERGENCY CLINIC

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 utiliza-tion 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