

Uptown Physicians Group Consent Form

Authorization To Release Information:

I hereby authorize Uptown Physicians Group to release to my insurance carrier(s) and to MDM Medical Management and Billing Company any information acquired in the course of my examination or treatment required for payment of any insurance claim.

Signed: _____ Dated: _____

Assignment of Benefits:

I hereby authorize payment directly to Uptown Physicians Group for medical benefits. I understand that I am financially responsible for the charges not covered by the insurance company.

Signed: _____ Dated: _____

Electronic Privacy Waiver:

I understand that my medical records may be transmitted electronically. Although every effort will be made to assure the records are sent/received by the appropriate third party, I absolve Uptown Physicians Group/David M Lee MD PA from liability should they be received in error by a third party. I give my consent to fax my records for the purposes of treatment, payment, or healthcare operations and understand that I may withdraw this consent at any time in writing.

Signed: _____ Dated: _____

Acknowledgement of Office Policies:

I am aware that I will be charged \$25 for missed appointments not cancelled 24 hours in advance. I am also aware that \$25 will be charged for preparation of FMLA/private disability forms at the time the forms are dropped off at the office.

Signed: _____ Dated: _____

Permission to Share Medical Information:

You have my authorization to share my medical records and medical information with the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signed: _____ Dated: _____

Permission to Leave Messages on Answering Machine:

By signing below you authorize us to leave messages regarding appointment reminders, referral information, etc. on the numbers/email address listed below.

Email Address: _____

Phone Number (_____) _____ - _____

Phone Number (_____) _____ - _____

Signed: _____ Dated: _____

By signing below you additionally authorize your physician to leave messages regarding abnormal lab values/other clinical information on the numbers/email address above.

Signed: _____ Dated: _____

Uptown Physicians Group Patient Consent Agreement

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

___ Accepted ___ Denied

(Signature of Patient or Legal Representative)

(Printed Name of Patient or Legal Representative)

(Date Notice Effective)

Name: _____ Age: _____ Sex: _____ Date: _____

Spouse/Partner Name: _____ Children: _____ Occupation: _____

Smoke? _____ Alcohol? _____ Drug Use? _____ Exercise Regularly? _____

Have you ever had?	Yes	No		Yes	No		Yes	No
Anemia			Cancer			Lung Disease		
Allergies			Ear Trouble			Prostate Trouble		
Arthritis			Eye Trouble			Reflux/Ulcers		
Asthma			Heart Disease			Skin Problems		
Cancer			Hepatitis			Thyroid Disease		
Depression/Anxiety			HIV/AIDS			STD		

Other Medical Problems

Previous Surgeries/Hospitalizations

Medications

Do you now have?	Yes	No		Yes	No		Yes	No
Weight Loss			Sore Throat			Constipation		
Loss of Energy			Trouble Breathing			Blood in Stool		
Fever/Chills			Wheezing			Hot Flashes		
Loss of Appetite			Coughing			Painful Urination		
Headache			Chest Pains			Discharge		
Dizziness			Racing Heart			Muscle Pain		
Fainting Spells			Swelling/Edema			Painful/Red Joints		
Blurred Vision			Nausea/Vomiting			Rash/Abnormal Mole		
Swollen Glands			Abdominal Pain			Numbness/Tingling		
Poor Hearing			Diarrhea			Depression/Anxiety		

Who in your family has been diagnosed with?

Heart Disease: _____

High Blood Pressure: _____

Diabetes: _____

Cancer: _____

Stroke: _____

Health Maintenance - When was your last?

Tetanus Shot? _____

Pneumonia Shot? _____

Flu Shot? _____

Pap smear/Mammogram? _____

Colonoscopy? _____

Uptown Physicians Group

Authorization to Release Information

This consent will need to be filled out/signed if you would like for us to obtain information from your previous physician(s) and/or if you would like us to send your information to a third party.

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone Number () _____ - _____

I authorize _____ to release medical information from my medical record to:

Name of Doctor/Hospital/Recipient: _____

Address _____ City _____ State _____ Zip _____

For the purposes of (for example review/examination) _____ and further authorize you to provide such copies thereof as may be requested. The foregoing is subject to such limitation as indicated below: (initial)

_____ Entire Record _____ Specific Information (describe below) _____ Old Records

I give special permission to release any information regarding: (initial)

_____ Substance Abuse _____ Psychiatric/Mental Health _____ HIV/AIDS

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken to reliance thereon. My written revocation must be submitted to the privacy officer of Uptown Physicians Group.

Patient Signature _____ Date _____

Received by: _____ Office Use Only Completed by: _____

Completed: _____ Fee Paid: _____

Disclosure Consisted of: _____

