Trace Medical Clinic **530 Veterans Memorial Drive** **Kosciusko, MS 39090** **(662) 289-9155**

Patient Demographic & Insurance Information

Patient's Social Security Number_____ Birth Date_____ Gender **F M**

Name of Patient_____
First Middle Last

Street Address_____ City_____ State_____ Zip_____

Home Phone (_____)_____ Work Phone (_____)_____ Cell Phone (_____)_____

E-Mail Address _____Race/Ethnicty_____

Patient's Employer_____ Patient's Occupation_____

Employer Address_____City_____State_____Zip_____

Patient's relationship to Guarantor: ☐ Self ☐ Child ☐ Spouse ☐ Guardian ☐ Other_____

«««Please present your Insurance Card & Driver's License to the receptionist for scanning.»»»

Billing Information / Responsible Party / Guarantor for Encounter

Guarantor (Person responsible for bill, if different from Patient)_____
First Middle Last

Street Address_____ City_____ State_____ Zip_____

Birth Date_____ Gender: **F M** Guarantor's Social Security #_____

Home Phone (_____)_____Work Phone (_____)_____Cell Phone (_____)_____

E-Mail Address _____ Race/Ethnicity _____

Guarantor's Employer_____ Guarantor's Occupation_____

Insurance Coverage - Primary

Name of Insurance_____ Effective Date_____ Expiration Date_____

Policy Number_____ Group Name_____ Retirement Date (if applicable)_____

Name of Insured_____
First Middle Last

Birth Date_____ Gender: **F M** Patient's Relationship to Insured_____

Name of Insured's Employer_____ Insured's Occupation_____

Address of Insurance Holder (if different than Patient Address) _____

City_____ State _____ Zip_____ Phone(_____)_____

Insurance Coverage - Secondary

Name of Insurance_____ Effective Date_____ Expiration Date_____

Policy Number_____ Group Name_____ Retirement Date (if applicable)_____

Name of Insured_____
First Middle Last

Birth Date_____ Gender: **F M** Patient's Relationship to Insured_____

Name of Insured's Employer_____ Insured's Occupation_____

Address of Insurance Holder (if different than Patient Address) _____

City_____ State _____ Zip_____ Phone (_____)

«««««Guarantor for account please read, sign and date below.»»»»»

For services rendered to the patient named above, I the undersigned agree to pay all professional, outpatient and/or hospital visit charges not covered by insurance. I also agree to pay reasonable attorney and/or collection fees necessary for the collection of payment. I further agree to allow Trace Medical Clinic to contact my employer to verify employment.

TMC Revised 12032009

_____ _____
Guarantor's Signature Date

«««««««««««PLEASE COMPLETE ADDITIONAL INFORMATION ON THE BACK OF THIS FORM »12062010»»»»

Additional Patient Information

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Patient's Employment Status ☐ Full-Time ☐ Part-Time ☐ None

Spouse's Employment Status ☐ Full-Time ☐ Part-Time ☐ None

Student Status (if applicable) ☐ Full-Time ☐ Part-Time ☐ None

Spouse's Name_____ Referral Source_____

Patient's Driver's License #_____ Spouse's Employer_____

«««««««Who do we thank for referring you?_____»»»»»»»

Emergency Contact Information – Primary Contact

Name_____
First Middle Last

Home Phone_(____)_____ Work Phone_(____)_____ Cell Phone_(____)_____

Street Address_____City_____ State_____ Zip_____

Notes / Special Directions_____

_____

Patient's Medical History

SERIOUS ILLNESS (please list)	Date	SURGERIES (please list)	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DRUG ALLERGIES (please list)_____

CURRENT MEDICATIONS (please list)_____

_____

FAMILY HISTORY - Please list any close family member that has had the following:

Diabetes_____ High Blood Pressure_____

Heart Disease_____ Stroke_____

Cancer_____ Tuberculosis_____

Other_____

OTHER INFORMATION PERTINENT TO YOUR MEDICAL TREATMENT_____

_____

«««««««PLEASE READ, SIGN AND DATE THE CONSENT FOR TREATMENT ON THE FOLLOWING PAGE.»»»»»»»

TRACE MEDICAL CLINIC
CONSENT FOR TREATMENT

Authorization for treatment, release of medical information, and assignment of insurance benefits.

CONSENT FOR TREATMENT: The undersigned authorizes the physician/provider assigned to furnish medical and surgical treatment by those means he/she considers necessary and proper in the treatment of the patient identified below while a patient of Trace Medical Clinic. This treatment may require diagnostic procedures including but not limited to laboratory tests, blood drawing for those tests, x-rays and electrocardiogram.

AUTHORIZATION TO RELEASE: I hereby authorize the Trace Medical Clinic or my attending physician/provider, to release or disclose to insurance companies and/or outpatient benefit programs information from my medical record pertaining to my treatment as needed to process insurance claims.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby irrevocably assign payment for services rendered and transfer to the Trace Medical Clinic benefits wherein specified and otherwise payable to me but not to exceed Trace Medical Clinic regular charges for medical treatment. I understand I am financially responsible for charges not covered by this authorization. A photostatic copy of the assignment shall be as valid and as effective as the original.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PHYSICIAN/PROVIDER: I certify that the information given by me in applying for payment under title XVII of the Social Security Administration or its intermediaries or carriers is the correct information needed for Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services, and authorize such physician/provider or organization to submit claims to Medicare for payment.

MEDICAID PATIENT CERTIFICATION: I certify that the information given by me in applying for payment as a recipient of the Medicaid Title XIX Program is correct and request that payment of authorized benefits be made on my behalf. I authorize any holder of medical or other information about me to make available to the Mississippi Medicaid Commission any requested information concerning medical, insurance, or financial records relating to my outpatient visits or hospital treatment. I hereby certify all insurance benefits shall be assigned to the Trace Medical Clinic or to my attending physician/provider for services rendered.

VALUABLES: The undersigned hereby releases the Trace Medical Clinic and/or its staff of employees from any responsibility due to loss or damage of any valuables that the patient may keep in his/her possession or that may be brought to him/her by other persons.

FINANCIAL AGREEMENT: For services rendered to the patient named below, I the undersigned, agree to pay all professional, outpatient and/or hospital visit charges not covered by insurance. I also agree to pay reasonable attorney and/or collection fees necessary for the collection of payment. I further agree to allow the Trace Medical Clinic to contact my employer to verify employment.

TERM: The term of this Consent shall begin on the date of signature as listed below and shall automatically be renewed annually under the same terms and agreements as stated above, unless otherwise revoked.

_____	_____	_____
Printed Patient Name	Signature of Patient	Date
_____	_____	_____
Printed Name of Guardian	Signature of Guardian (if patient is minor)	Date

Revision 12032009

<u>«««PLEASE READ, SIGN AND DATE THE PRIVACY CONSENT ON THE BACK OF THIS PAGE»»»</u>