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

PATIENT DEMOGRAPHIC WITH EMPLOYER AS GUARANTOR

Basic Patient Information --- to be completed by PATIENT

Patient's Social Security No._____ 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/Ethnicity _____

Patient's Employer_____ Patient's Occupation_____

Patient's relationship to Guarantor: ☐ Self ☐ Employee ☐ Other_____

Fax (_____)_____Pager (_____)_____

«««««««««PATIENT PLEASE READ, SIGN AND DATE THE CONSENT FOR TREATMENT BELOW. »»»»»»»»»

CONSENT FOR TREATMENT

Authorization for treatment, release of medical information, and financial agreement.

CONSENT FOR TREATMENT: The undersigned authorizes the physician assigned to furnish medical and surgical treatment by those means he/she considers necessary and proper in the treatment of the patients 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, 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

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 GUARANTOR. 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.

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.

_____ _____ _____
Printed Patient Name Signature of Patient Date

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

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GUARANTOR INFORMATION – EMPLOYER AS GUARANTOR

Billing Information / Responsible Party / Guarantor for Encounter --- to be completed by GUARANTOR

Name of Employer as Guarantor _____

Street Address_____

Billing Address (if different) _____

City_____ State_____ Zip_____

Contact_____ Billing Contact (if different) _____

Guarantor/Company's EIN: _____ Guarantor or Company Owner: _____
Must have Employer's ID Number

Company Phone (_____)_____Accounts Payable Phone (_____)_____

Fax (_____)_____ Pager (_____)_____

REASON FOR ENCOUNTER: *(Please check all that may apply.)* ☐ Urine Drug Screen (DOT) ☐ Breath Alcohol Test (DOT)

☐ Urine Drug Screen (Non-DOT) ☐ Breath Alcohol Test (Non-DOT) ☐ Urine Drug Screen – Collection Only

☐ Urine Drug Screen (10 test) ☐ Pre-Employment Physical ☐ Pulmonary Function Test ☐ Audiometric Exam

☐ Other _____

«««««««««**GUARANTOR PLEASE READ, SIGN AND DATE THE FINANCIAL AGREEMENT BELOW**. »»»»»»»»»

Employer as Guarantor Financial Agreement

FINANCIAL AGREEMENT: For services rendered to patients employed by my company and referred by my company, I the undersigned, as authorized by the above listed employer, agree to pay all professional, outpatient and/or hospital visit charges for employment related services provided by Trace Medical Clinic. I also agree to pay reasonable attorney and/or collection fees necessary for the collection of payment

_____ _____
Printed Name Authorized Signature

_____ _____
Title Date

Employers may return completed information form by:

Fax: (662)289-7752
or
Mail: 530 Veterans Memorial Drive Kosciusko, MS 39090