Physicians Health and Injury Center

Date_____ Eval ___Y___ N ___

Patient Name_____ Maiden Name _____

What name would you like us to call you? _____

Street Address _____ Mailing Address (if different)_____

City/State _____ Zip Code_____

Social Security Number _____ Date of Birth _____ Sex M F

Marital Status S M Employer _____ ***Student Y N***

Where can we contact you? ***If other than patient:*** ***Is it ok to leave a message?***

*Home Phone _____ ask for _____ Y N

*Work Phone_____ ask for _____ Y N

*Cell Phone_____ ask for _____ Y N

Email_____

How early in the morning can we call you? _____ ***Area to be treated*** _____

Whom may we thank for referring you? _____

Referring Dr _____ PCP _____

Is this due to a (circle) **W/C MVA Liability N/A** Date of Injury/_____ City_____ State_____

If MVA is circled, is there Medical Coverage on the *car you were in?* **YES NO**

YES? *provide billing information.* **NO?** *you will need to provide a letter from your Insurance stating, there is no medical coverage.*

Is there an Attorney Involved? **Y N** Name_____ Phone _____

Briefly describe what happened _____

Primary Insurance Information

Insurance Company _____ Phone Number _____

Insurance ID/Claim # _____ Group Name /# _____

Policy Holder Name _____ DOB_____ SSN_____

Employer_____

Adjuster Name _____ Phone Number _____

*DO YOU HAVE A SECONDARY INSURANCE Y N If yes, please fill out this section

Secondary Insurance Information

Insurance Company _____ Phone Number _____

Insurance ID/Claim # _____ Group Name /# _____

Policy Holder Name _____ DOB_____ SSN_____

Employer_____

By signing below _____ I hereby agree and give consent to medical treatment necessary in treating my physical condition. I authorize the release of any medical information needed to process my claim. I understand that I am responsible for any non-covered charges. Should my Insurance change during the course of my treatment I will provide the office with all necessary information to process my claim. Should I fail to provide this information and claims are denied as a result, I will be responsible for the denied visits. I authorize payment directly to Physicians Health.

Signature_____ Date_____

Relationship to Patient _____

For minor child:

I hereby allow my child to be treated at **Physicians Health** without my presence.

Signature_____ Date_____

Relationship to Patient _____

8B CHRISTOPHER COLUMBUS AVE
DANBURY, CT 06810
203-778-6612 Fax Email: Phic4b@gmail.com

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____