DATE:________

Patient Information

Name:____ Age:_____ Phone:_______________

Address:____ City:_______________ State:_____

Zip:_________ Date of Birth:_____________ Social Security:______________________________

Have you been Seen Here Before? **YES** **NO**

What is your emergency?____

Primary MD?_______________________________ Phone:____________________________________

Was your injury work related? **YES** **NO**

Responsible Party Information

Name:___________________________________ Relationship to Patient:_______________________________

Address: ____

Date of Birth:______________ Social Security #:____________________ Phone:_________________________

Work Phone:_____________________________ Cell Phone:_____________________________

Insurance Information

Primary Insurance:______________________________ (Insured) Name:_________________________________

Secondary Insurance:____________________________ (Insure) Name:__________________________________

General Information

As a patient of Alamo Heights Minor Emergency Clinic ("AHMEC"), YOU ARE REQUESTING MEDICAL TREATMENT and consent to the treatment deemed medically appropriate by AHMEC staff. When you seek medical advice or receive medical care from us, **P**rotected **H**ealth **I**nformation (**PHI**) will be generated about you. This information includes your medical information (past, present, and future) and personal information such as your name, address and social security number. This information will be used for the **T**reatment of your medical condition(s), obtaining **P**ayment from your insurance company and for Healthcare **O**perations (**TPO**) within AHMEC.

Your signature below acknowledges:

- You have read and understand this consent.
- You agree to have your protected health information used and disclosed by AHMEC for the purpose of your treatment, to secure payment for your treatment, and for AHMEC's healthcare operations.
- Prior to signing this consent, you were given the opportunity to review AHMEC's "Notice of Privacy Practices".
- You are permitting the release of your protected health information to the persons noted above.
- You are aware that you may now or at any time request restrictions to the use and disclosure of your protected health information.

I hereby authorize Alamo Heights Minor Emergency Clinic ("AHMEC") to furnish any information pertaining to my medical treatment to my insurance carrier, worker's compensation representative, attorney, employer, or other provider of services. I request that payment from my insurance company be made directly to AHMEC. I understand that my insurance company is a contract between myself and the insurance company and I am ultimately responsible for any balance on my account. I hereby authorize AHMEC to apply for benefits on my behalf for covered services.

Signed:____ Date:___________________________________