alamo heights minor Emergency clinic, p.a.
Taking Emergency Care To New Heights.

Patient Consent Form T106

Name:_____
Complaint:_____
Age:_____ **DOB:**_____
Insurance Changes? ☐YES ☐NO
PrimaryInsurance:_____
Primary Insured DOB: _____

Payment, Health Care Operations, & Release of PHI

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.

Notice of Privacy Practices
For a description of how your Protected Health Information may be used and disclosed, you may review AHMEC's "Notice of Privacy Practices" prior to signing this consent. AHMEC reserves the right to change the notice and will notify all patients of such changes prior to the effective date.

Patient Rights
You have the right to request a restriction of the uses and disclosures of your **P**rotected **H**ealth **I**nformation (**PHI**) for the purpose of your treatment, payment for your services and the healthcare operations of AHMEC. We are not required to agree to the requested restrictions, but we are bound by any restrictions agreed upon.

Permission to Release Your Protected Health Care Information to Family Members or Others
Please indicate below the person's name(s) to whom you authorize us to release medical and/or insurance information.

Name	Relationship	Date of Birth
Name	Relationship	Date of Birth
Name	Relationship	Date of Birth

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AHMEC has the right to refuse to treat you if you refuse to sign this consent or if, at any time, you choose to revoke this consent. In addition, AHMEC is authorized by law to use and/or disclose your PHI in certain circumstances without your consent.

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.

_____ _____
Signature of Patient or Patient's Representative Date

Address:_____ ZIP_____ Phone:_____