



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

RED FLAG RULES! In an attempt to minimize identity theft, new Federal Regulations mandate that we obtain patient demographics EVERY VISIT, to include a drivers license, insurance card, current address and phone numbers. If the address on your driver's license does not match your home address, federal regulations mandate that you bring in a copy of a utility bill to confirm correct address. If you suspect that you have been a victim of identity theft, please let us know as soon as possible.

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: _____ (Insured) 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, Protected Health Information (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 Treatment of your medical condition(s), obtaining Payment from your insurance company and for Healthcare Operations (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:** _____