Please Print **Date:**__________________________

Date of Birth_______________________ ( )Male ( ) Female Marital Status_________________________

Name (as shown on insurance card)____

Address____City___________________________State_______Zip __________

Cell Phone____ Home Phone___________________________________

E-Mail_______________________________________ Primary Care Dr_________________________________

Emergency Contact Name____ Phone #__________________________

HIPAA Contact _______________________________________ Employed ( )Yes ( )No Leave Message ( ) Yes ( ) No

INSURANCE

Primary Insurance Name ____

Policy Holder Name if different than Patient____ Date of Birth_______________

Relationship_______________________

Secondary Insurance Name ____

Policy Holder Name if different than Patient____ Date of Birth___________________

Relationship______________________

Insurance Assignment, Release of Information and Financial Disclosure

I hereby assign Daniel Briceland MD, Susan Briceland MD or Charles Schaffer MD payment from my insurance for services rendered. I understand that I am financially responsible for all charges, whether they are paid by insurance or not. I authorize the doctor's staff to release all necessary information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

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Signature of Patient or Guardian

I hereby authorize Daniel Briceland MD, Susan Briceland MD or Charles Schaffer MD to release information acquired during the course of my examination or treatment to my referring physician, my primary care doctor or to an appropriate insurance carrier. If a Medicare patient, I further authorize release to the Center for Medicare Services and its agents any information needed to determine benefits payable for related charges.

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Signature of Patient or Guardian

Patient General Consent to Treat

I, the under signed, hereby consent to the following: Administration and performance of general treatments. Use of prescribed medications. Performance of diagnostic procedures/tests/cultures when warranted. Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees.

I fully understand that this consent is given in advance of any specific diagnosis or treatment.

I intend that this consent is continuing in nature. This consent will remain in full force until it is revoked in writing. I have also been informed that a photocopy of this consent shall be considered as valid as the original.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____ __________________________________

Signature of Patient or Guardian