"WE DO ORDINARY THINGS EXTRAORDINARILY WELL"

Patient name: ____

Marital Status: { } Married { } Single { } Divorced { } Widowed { } legally separated { } other

Social Security #:____________________ Date of Birth: ______________________ E-Mail: ____________________________________
Phone numbers : Work:_______________________ Cellular:________________________________Home:_________________________
Address:_____________________________ City/State/Zip code: ____
Employment Status : { }Employed { } Full-time student { } Part=time student { } Retired { } Self-employed { } Unemployed
Employer:_______________________________________ Occupation: ____
Emergency contact name:________________________________Relationship to patient: __________ Phone number:__________________
Referring Provider name:____

RESPONSIBLE PARTY INFORMATION Responsible party(NAME):____
DATE OF BIRTH:________{ } Female { } Male Social Security #:_______________ E-mail: ________________________________
Phone numbers: Work:____________________________ Cellular: ___________________________ Home: ______________________
Address:_____________________________ City/State/Zip code: ____
Employment Status: { } Employer { } Full-time student { } Part-time student { } Retired { } Self-employed { } Un-employed
Employer: ____ Occupation: ________________________________
Patient Relationship to responsible party: ____

PRIMARY INSURANCE INFORMATION (PLEASE PROVIDE YOUR INSURANCE CARD TO THE FRONT DESK)

Name of Insured: ___________________________________Patient relationship with insured:______________________________
Social Security #:____Date of Birth:____
Insurance Company/Phone number: ____
Subscriber ID(Policy #):_____________________________Group ID: _________________________ Copay amount:_________________
Effective Date :_______________________Termination Date: ___________________ { }Female { } Male
Insurance Company Address: ____

SECONDARY INSURANCE

Name of Insured:___________________________________ Patient relationship with insured:______________________________
Social Security Number:_____________________________________ Date of Birth:____
Insurance Company/Address/Phone #:____
Subscriber ID(Policy #): ____________________________Group ID: __________________________Co-pay:____________________
Effective Date: _________________________ Termination Date:_______________________ { } Female { }Male

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or responsible party) Signature: ____ Date: ________________________

PREFFERED PHARMACY: ________________________________

PATIENT CONSENT FORM

I, the undersigned, hereby consent to the following:

- **Administration and performance of all treatments**
- **Administration of any needed anesthetics**
- **Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient**
- **Use of prescribed medication**
- **Performance of diagnostic procedures/tests**
- **Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.**

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. I understand that Patrick Ellis, M.D. includes consent at satellite offices under common ownership. I the undersigned, acknowledge that Patrick Ellis, M.D. will use and disclose my information for the purposes of treatment, payment, and healthcare operations.

TREATMENT includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory test, all of which the judgment of the attending physician or their assigned designees, may be considered medically necessary or advisable.

PAYMENT includes but is not limited to: the authorization of payment directly to Patrick Ellis, M.D. or benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized person to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury, to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge the patient records may be stored electronically and made available through computer networks.

HEALTHCARE OPERATIONS include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies' participation in my care or treatment and the quality of that care.

This consent specifically includes the release of medical information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases including but not limited to blood-borne diseases.

A photocopy of this consent shall be considered as valid as the original.

If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person exposed, and the Public Health Department and appropriate counseling will be offered.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Patrick Ellis, M.D.

I acknowledge that I have been given the Notice of Privacy Practices (Patrick Ellis M.D>) I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: ______________

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

NAME: ____

NAME: ____

NAME: ____

PATIENT (OR RESPONSIBLE PARTY) SIGNATURE: ____ **DATE:** ______________________

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME: ____

DATE OF BIRTH: ________________ SOCIAL SECURITY NUMBER: ____________________

INFORMATION TO BE RELEASED FROM: (PREVIOUS DOCTOR)

____
____
____
____
____

INFORMATION TO BE RELEASED TO:

PATRICK ELLIS M.D.
100 E. ALTON GLOOR STE 300
BROWNSVILLE, TX 78526
PHONE: (956) 350-2245 FAX: (956) 350-9557

PURPOSE OF RELEASE OF PHI: **CONTINUED CARE** .

DESCRIPTION OF INFORMATION TO BE RELEASED:

- ✓ **PROGRESS NOTES: INCLUDING HISTORY AND PHYSICAL**
- ✓ **LAVORATORY REPORTS(INCLUDING PATHOLOGY REPORTS)**
- ✓ **RADIOLOGY REPORTS (ULTRASOUNDS/SONOGRAMS, X-RAYS, CT SCANS, MRI)**
- ✓ **CONSULTATIONS**
- ✓ **HOSPITAL RECORD: EMERGENCY RECORDS, ADMISSION/REGISTRATION RECORDS, OPERATIVE REPORTS, DISCHARGE SUMMARY)**
- ✓ **SPECIFIC WORK RELATED FORMS, FMLA, DISABILITY, GENERAL WORK STATUS/RELEASE**

I UNDERSTAND THAT:

- **ANY INFORMATION THAT WAS NOT GENERATED BY DR. PATRICK ELLIS WILL NOT BE REALEASED AND MUST BE REQUESTED BY THAT FACILITY DIRECTLY.**
- **THIS AUTHORIZATION WILL EXPIRE BY LAW 180 DAYS FROM THE DATE OF THIS AUTHORIZATION UNLESS I OTHEWISE SPECIFY; I DESIRE THIS AUTHORIZATION TO BE IN EFFECT UNTIL (DATE) ________________________.**
- **BY SIGNING THIS FORM I AM AUTHORIZING AT ANY TIME WITH WRITTEN NOTIFICATION, BUT WILL NOT AFFECT INFROMATION THAT HAS ALREADY BEEN RELEASED OR ACTIONS TAKEN PRIOR TO THE WRITTEN REVOCATION. WRITTEN REVOCATION MUST BE SIGNED AND DATED WITH A DATE THAT IS LATER THAN THE DATE OF THIS AUTHORIZATION.**
- **THERE MAY BE A CHARGE ASSOCIATED WITH THE RELEASE OF INFORMATION SERVICES RENDERED.**
- **THERE IS NO CHARGE FOR THE RELEASE OF INFORMATION TO OTHER HEALTH CARE FACILITIES.**
- **I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN IT.**

PATIENT SIGNATURE: ______________________________________ DATE: ____________________