Jeffers, Mann and Artman Pediatric & Adolescent Medicine P.A. (JMA)

Patient Information 18+

Last Name_____ Patient Home Phone #_____

First Name_____Middle Initial_____ **Patient Mobile #** _____Work#_____

DOB _____ Gender (Circle) Male Female Patient Email _____

Address_____ Preferred Provider_____

City_____Zip Code_____ Language_____Race_____

Mothers Maiden Name_____ Insurance Company_____

Ethnicity (Please Circle)

Hispanic/Latino Non-Hispanic/Latino Declined

By my signature below, I hereby authorize **JMA** to disclose my medical information for the purposes of:

- Providing treatment to me
- Seeking payment from third parties for such treatment
- Conducting health care operations (e.g., quality assurance)

I also authorize the JMA to disclose my medical information to **outside insurers and health care providers** as necessary so they may:

- Provide treatment to me
- Seek payment for that treatment
- Conduct their own health care operations

Disclosure Preferences (please check box/boxes that apply and fill in applicable information):

- ☐ I understand that I may request JMA to restrict the disclosure of my health information to family members and/or their insurance plans. However, doing so means my family's health plan cannot be billed for my visit or tests, and I will be personally responsible for all charges.
- ☐ I authorize JMA to disclose my **health information** to the following individuals:
  Name: _____
  Phone: _____
  Relationship to Patient: _____
  Name: _____
  Phone: _____
  Relationship to Patient: _____
- ☐ I authorize JMA to disclose **financial information** to the following individuals:
  ☐ Same name and relationship as above for **health information** disclosure
  Name: _____
  Phone: _____
  Relationship to Patient: _____
  Name: _____
  Phone: _____
  Relationship to Patient: _____

ASSIGNMENT OF INSURANCE BENEFITS

By my signature below, I authorize medical benefits to be paid directly to **JMA** for services provided by their medical and clinical staff. I understand that:

- I am financially responsible for **all charges**, regardless of my insurance coverage.
- This responsibility applies to **today's visit** and **all future visits**.

_____ _____ _____

Signature of patient who is over 18 years old or minor/emancipated minor | **Relationship to patient** | **Date**

Office Use Only_____ _____

Initial *Date*