Jeffers, Mann and Artman Pediatric and Adolescent

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

CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION

By my signature below, I hereby authorize the Jeffers Mann and Artman Pediatric and Adolescent Medicine, P.A. to disclose my medical information so that the Practice may treat me, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations (e.g., quality assurance). I also authorize the Practice to disclose my medical information to insurers and providers outside of the Practice when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations.

I authorize Jeffers Mann and Artman Pediatric and Adolescent Medicine, P.A. to disclose my health information to the following family members/friends

(I understand I may instruct Jeffers Mann and Artman Pediatrics and Adolescent Medicine, P.A. to limit disclosure of my health information to family members and/or their insurance plans but by doing so my family's health plan cannot be billed for my visit or test and I shall be financially responsible to pay all charges directly):

☐ **None**

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 to Jeffers Mann and Artman Pediatrics and Adolescent Medicine, P. A. on my behalf for any service provided by the medical and clinical staff of the practice. I understand that I am responsible for all charges, regardless of insurance coverage, for this service date as well as all future service dates.

_____ _____ _____

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

Office Use Only_____ _____

Initial *Date*