Olive Branch Family Medical Center
obfmc
9075 Sandidge Center Cove
Olive Branch, MS 38654
PH: (662) 895-4949 FX: (662) 895-6776
www.obfmc.com

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
Social Security # _____ Age: _____ Marital Status: _____ Sex: _____
Race: _____ Ethnicity: _____ Email: _____
Home Phone: _____ Cell Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Employer Phone: _____
Employer Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Name: _____ Phone: _____
Relationship: _____

GUARDIAN/SPOUSE INFORMATION

Guardian/Spouse Name: _____ Cell Phone: _____
Date of Birth: _____ Social Security # _____
Address: _____ City: _____ State: _____ Zip: _____

PRIMARY INSURANCE

Must have Social Security Number for the Policy Holder.

Insurance Company Name: _____
Claims Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ ID #: _____ Group #: _____
Insured Name: _____ DOB: _____ S.S. #: _____

SECONDARY INSURANCE

Must have Social Security Number for the Policy Holder.

Insurance Company Name: _____
Claims Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ ID #: _____ Group #: _____
Insured Name: _____ DOB: _____ S.S. #: _____

I understand **Olive Branch Family Medical Center** is not a provider for MS Medicaid or TennCare. I hereby assign all medical and/ or surgical benefits to include major medical benefits to which I am entitled including all private insurance and other health plans to OBFMC, this assignment will remain in effect until revoke by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize assignee to release all information to secure payment. I understand that I am financially responsible for all charges whether paid by insurance. I agree to pay interest on any past due monthly account balance. Should my account be placed with a collection agency or referred to an attorney for purposes of seeking judicial relief, I agree to pay all costs of collection, reasonable attorney's fees, expenses, all cost of court, plus pre- and post-judgment interest on any judgment. PAYMENTS IS DUE AT TIME OF SERVICE.

Patient/Guardian Signature: _____ Date: _____

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Patient's Name: _____ Date of Birth: _____

Authorization to disclose PHI

Please note: Any person that is not listed below will not be able to obtain any information regarding your PHI from this office. Insurance companies or other physicians do not need to be listed.

I hereby authorize OBFMC to leave a message and/or discuss my protected health information (PHI), to include account information, test results, schedule appointments, and information regarding my healthcare with the following people:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Please initial each and sign at the bottom

Receipt of Notice of Privacy Practices

_____ I have been notified of OBFMC's Notice of Privacy Practices and been offered an
INITIALS copy of these documents.

Consent for Care

_____ I hereby give my consent for treatment to OBFMC. If patient is minor,
INITIALS authorization will remain in effect until the age of 18 or until
written notice is given to OBFMC from guardian.

Receipt of Collection Policy

_____ I have been notified of OBFMC's Credit and Collection policy and been offered a
INITIALS copy of these documents.

Authorization to pat benefits to Physician and file Medicare/ Commercial Insurance Claims

_____ I authorize OBFMC to file claims to and collect payments from my insurance
INITIALS company for service rendered to me or my dependents until such agreement is terminated in writing. I also authorize the release of any information necessary for claim payments. I understand that I am responsible for balances that are not covered by my insurance, co-pays, deductibles, and co-insurance amounts required by my insurance. Collection costs and legal fees incurred to collect a balance owed is the responsibility of the patient and/or responsible party.

Signature: _____ Relationship: _____ Date: _____
Patient or Guardian

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Medical Record Release Form

Date: _____

I hereby authorize disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by federal privacy regulations.

Patient's Name: _____ S.S.#: _____ Date of Birth: _____

The Information you may release subject to this signed release form is as follows:

____ Complete Records ____ Radiology Report ____ Lab Results Only

____ Other (please specify): _____

Release/Request my protected health information to the following:
Physician/Person/Facility/Entity and/or those directly associated in my medical care:

Please complete one form for each physician that you see.

Release To:
Name: _____
Address: _____
Phone: _____ Fax: _____

Request From:
Name: _____
Address: _____
Phone: _____ Fax: _____

If you do not want certain portions of your medical records released, please read this section carefully and initial the boxes for the information you do not want released. Otherwise, your records will be released as specified above. I authorize the health care provider to release the information specified to the organization, agency, or individual name above with exception of:

____ Substance Abuse ____ AIDS/HIV ____ Psychological conditions

____ Other (please specify): _____

I understand that I have the right to revoke this authorization at any time by presenting my written revocation to OBFMC. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If this authorization has not been revoked, it will terminate on the following date, even or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will automatically be expired in 12 months.

Print Name: _____
Signature: _____ **Relationship:** _____