Patient Information Sheet/Patient Privacy & Rights
Port Lavaca Clinic Associates

Patient Reviewed: _____
Employee Updated: _____

Patient Demographics	Person Responsible for Bill
Patient Full Name: _____ ☐ Female ☐ Male Date of Birth _____ Driver's License#: _____ SS#: Address: Phone#: Race:_____ Ethnicity:_____ Preferred Language:_____ Email address:_____	Responsible Party's Full Name: _____ Address:_____ Phone Number:_____ Social Security: _____ Date of Birth:_____ Relationship to Patient: _____

**** Please list spouse and minor children under the age of 21 who you are responsible for ****

1.	2.	3.
4.	5.	6.

* Emergency Contact *

Name _____ Phone# _____ Relationship _____

Insurance Information

Primary Ins	** Second Ins.
Policy Holder: Relation to Policy Holder: Policy Holder DOB: Policy# Group# Female/Male SS# of insured:_____ EMPLOYER: _____	Policy Holder: Relation to Policy Holder: Policy Holder DOB: Policy# Group# Female/Male SS# of Insured_____ EMPLOYER: _____

*** THIRD INS:

POLICY HOLDER:

RELATION TO POLICY HOLDER:

Policy Holder Date of Birth:

Policy# Group #

SS # of insured: Female/Male

PATIENT BILLING AND PRIVACY

BY SIGNING BELOW YOU ARE CERTIFYING THAT THE ABOVE INFORMATION IS ACCURATE, that you are consenting for medical care & giving Port Lavaca Clinic Associates, PA. Permission to bill your insurance carrier for all medical care provided here. Your signature on this paper will be the signature on file giving us permission to file your insurance claim with "Signature on File" for Medicare, Medicaid, and all other types of insurance. YOU ARE ALSO AGREEING THAT PAYMENT OF YOUR MEDICAL CARE IS ULTIMATELY YOUR RESPONSIBILITY. You are also authorizing the release of any medical or other information necessary to process your medical claims as well as to other referring providers. You have access to all of your personal medical records during normal business hours. Records will be provided no more than 15 business days from receipt of request. A fee for this may be required. If you find errors in your medical records you have the rights to request changes to correct any errors. You have the right to request disclosure of non-routine disclosures of your health information. Your signature also shows that you have received our two pages Notice of privacy practice form.

_____ _____

Patient Signature (Responsible Adult if Patient is under 18 yrs. old) Date