PATIENT DATA SHEET

NAME_____DOB _____

ADDRESS_____
CITY_____STATE_____
ZIP CODE_____HOME PHONE_____

E-MAIL_____

POLICY HOLDER OF HEALTH INSURANCE (IF OTHER THAN SELF)

_____
DOB_____POLICYHOLDER'S EMPLOYER
_____

PLEASE APPOINT SOMEONE TO NOTIFY IN CASE OF AN EMERGENCY:
NAME_____
PHONE_____

NOTICE OF DEEMED CONSENT

WHENEVER A PERSON RENDERING HEALTH CARE IS DIRECTLY EXPOSED TO A PATIENT'S BODY FLUIDS, OR A PATIENT COMES IN CONTACT WITH A CAREGIVER'S BODY FLUIDS, IN A MANNER THAT MAY TRANSMIT THE HUMAN IMMUNODEFICIENCY VIRUS OR HEPATITIS VIRUS, SUCH A PATIENT OR CAREGIVER IS DEEMED TO HAVE CONSENTED TO TESTING FOR AIDS OR HEPATITIS VIRUS WITHOUT WRITTEN CONSENT. THE RESULTS OF THESE TESTS MAY BY LAW BE RELEASED TO THE INDVIUAL SO EXPOSED, WITHOUT THE OTHER INDIVIDUAL'S CONSENT.
I HAVE READ AND UNDERSTAND THIS NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING.

BILLING AGREEMENT

I ACKNOWLEDGE FULL RESPONSIBILITY FOR PAYMENT OF SERVICES RENDERED TO ME. I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO MY INSURANCE COMPANY(IES) CONCERNING ANY ILLNESS AND TREATMENT IF IT IS REQUESTED BY THEM.

PLEASE NOTE THAT PAYMENT IS ACCEPTED IN CASH, CHECK OR CREDIT CARD ONLY. INSURANCE WILL NOT BE BILLED DIRECTLY, BUT A SUPERBILL (OR RECEIPT) WILL BE PROVIDED TO YOU SO THAT YOU MAY SEEK REIMBURSEMENT FROM YOUR INSURANCE COMPANY.

I AGREE TO PAY MY BALANCE IN FULL AT THE TIME SERVICES ARE RENDERED.

SIGNATURE:_____

DATE_____