**MEMORIAL HERMANN MEDICAL GROUP**
**Confidential Patient Information**

**Today's Date:**

| Patient Information | | | | |
|---|---|---|---|---|
| **Name** | | | **SS#** | |
| **Address** | | | **City, State** | **Zip Code** |
| **Home Phone** | **Cell Phone** | **Work Phone** | **Email** | |
| **Preferred Method of Contact: (Circle One)** Home Phone Cell Phone Work Phone Email | | | | |
| **Birth date** | **Age** | ☐ Male ☐ Female | | |
| **Race (Circle One): American Indian/ Alaskan Native Asian/ Pacific Islander Black White Decline** | | | | |
| **Ethnicity (Circle One): Hispanic Origin Not of Hispanic Origin Decline** | | | | |
| **Employer/School** | | | | |
| **Emergency Contact** | | **Relationship** | **Phone** | |
| **How did you hear about us?** | | **Is today's visit related to: work or accident** | | |

| Insured Information | | | |
|---|---|---|---|
| **Person Who Carries Insurance** | | **Relationship to Patient** | |
| **Address (if different)** | | **City, State** | **Zip Code** |
| **Home Phone** | **Cell Phone** | **Work Phone** | **Email** |
| **Birth date** | **SS#** | ☐ Male | ☐ Female |

## Consent to Treatment

☐ I am the patient or ☐ I am the parent/guardian of the patient or ☐ Other Relationship _____

I hereby authorize such medical care, treatment, and diagnostic tests as may be recommended and understand there is no warranty or guarantee of result or cure. This consent will remain in effect until I withdraw my consent in writing. I understand that medical students, under supervision, may be involved in my care.

**Signature of Patient/Parent/Guardian**: **Date**:

## Acknowledgement of Receipt of Office & Financial Policy

☐ I am the patient or ☐ I am the parent/guardian of the patient or ☐ Other Relationship _____

I acknowledge that I have received the Office and Financial Policy for Memorial Hermann Medical Group and agree to its terms.

**Signature of Patient/Parent/Guardian**: **Date**:

**A photocopy or faxed copy of these authorizations shall be deemed as valid as the original**

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## Authorization to Leave Recorded Voice Messages

☐ I am the patient or ☐ I am the parent/guardian of the patient or ☐ Other Relationship _____

I herby give my permission for MHMG Physicians and Staff to leave messages regarding office visits and appointments as well as any other medical information related to my treatment at the phone number(s) listed below:

Home: _____ Work: _____ Cell Phone: _____

**Signature of Patient/Parent/Guardian**: **Date**:

## Acknowledgement of Receipt of Joint Notice of Privacy Practices

This Joint Notice of Privacy Practices applies to the privacy practices of the Affiliated Entities and the Entities participating in the Organized Health Care Arrangement. These Entities include: Memorial Hermann Hospital System, Memorial Hermann Continuing Care Corporation, Memorial Hermann Affiliated Services, Memorial Hermann Physicians of Texas, Memorial Hermann Ventures, Inc., Memorial Hermann Health Network Providers, Inc., Memorial Hermann Healthcare System, Memorial Hermann Foundation, Memorial Hermann Professional Insurance Co., Ltd., Physicians and Allied Professionals with privileges to practice at a Memorial Hermann Healthcare Facility.

This form is used to document (a) an individual's acknowledgement of receipt of our Joint Notice of Privacy Practices or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

**SECTION A: The Individual**

**SECTION B: Acknowledgement of Receipt of Joint Notice of Privacy Practices.**

I acknowledge that I have received a Joint Notice of Privacy Practices from Memorial Hermann Healthcare System.

**Signature**: _____ **Date**: _____.

If this acknowledgement is signed by a personal representative on behalf of the individual, complete the following:

**Personal Representative's Name**: **Relationship to Individual**:

**SECTON C: Good Faith Effort to Obtain Acknowledgement of Receipt**

Describe your good faith effort to obtain the individual's signature: _____

_____

Describe the reason why the individual would not/could not sign this form: _____

_____

**Signature:** _____ **Date**:_____.

**Print Name:** _____ **Title:**_____.

**Include this Acknowledgement of Receipt in the Individuals Medical Record**

**A photocopy or faxed copy of these authorizations shall be deemed as valid as the original**

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## Assignment of Benefits

☐ I am the patient or ☐ I am the parent/guardian of the patient or ☐ Other Relationship _____

I acknowledge full responsibility for the payment of services received and agree to pay them in full at the time of service unless other arrangements have been made. I understand that insurance coverage is an arrangement between the insurance carrier and the patient. Memorial Hermann Medical Group will assist in billing my insurance company, but I am ultimately responsible for payment should my insurance fail to pay within a reasonable amount of time.

I authorize Memorial Hermann Medical Group to bill my insurance or third-party payer and receive payment directly from them for services rendered. I also authorize Memorial Hermann Medical Group to release information as required to my insurance or third-party payer (including my employer's worker's compensation carrier), for the purpose of determining benefits. I understand that such records may include information regarding HIV/AIDS testing, substance abuse and/or mental health issues. A photocopy or a faxed copy of this authorization shall be deemed as valid as the original.

My signature signifies acceptance of all terms in this Assignment of Benefits.

**Signature of Patient/Parent/Guardian**: **Date**:

**Staff Witness to Signatures:** **Date Witnessed:**

**A photocopy or faxed copy of these authorizations shall be deemed as valid as the original**