Patient Demographic

Are you here because of an injury? ☐ **Yes** ☐ **NO** **Date of Injury ____/____/____** ☐ **Work** ☐ **Auto** ☐ **Other**

PATIENT INFORMATION

PATIENT NAME (Last, First, Middle Initial)			SOCIAL SECURITY NUMBER		DATE OF BIRTH	SEX ☐ M ☐ F
MAILING ADDRESS		APT/SUITE#	CITY	STATE	ZIP	
PHYSICAL ADDRESS (IF DIFFERENT)		APT/SUITE#	CITY	STATE	ZIP	
RACE	LANGUAGE		ETHNICITY	MARITAL STATUS		
HOME PHONE	CELL PHONE		EMAIL ADDRESS			
PRIMARY CARE PHYSICIAN	**PHONE NUMBER**		PREFERRED CONTACT NUMBER WHERE WE MAY LEAVE MESSAGES ABOUT YOUR HEALTHCARE? ☐ **Home Phone** ☐ **Work Phone** ☐ **Cell Phone**			
EMPLOYER		WORK PHONE	HOW WOULD YOU LIKE TO BE NOTIFIED OF FUTURE APPOINTMENTS? ☐ TEXT ☐ PHONE CALL ☐ BOTH			
EMPLOYER ADDRESS		SUITE#	CITY	STATE	ZIP	
EMERGENCY CONTACT (first name last name)			PHONE	DATE OF BIRTH	RELATIONSHIP	

INSURANCE INFORMATION

PRIMARY INSURANCE

POLICY HOLDER NAME	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent	SOCIAL SECURITY NUMBER	DATE OF BIRTH	EFFECTIVE DATE
INSURANCE CARRIER	POLICY #	GROUP #	EMPLOYER	

SECONDARY INSURANCE

POLICY HOLDER NAME	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent	SOCIAL SECURITY NUMBER	DATE OF BIRTH	EFFECTIVE DATE
INSURANCE CARRIER	POLICY #	GROUP #	EMPLOYER	

Medicare Patients only: Are you entitled to Medicare because ☐ **AGE** ☐ **DISABILITY** ☐ **ESRD**

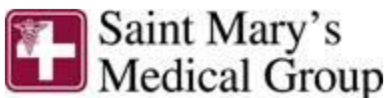
Is someone else or another entity responsible for the billing claim from this visit? ☐ YES ☐ NO WHO________________

PARENT/GUARDIAN INFORMATION *(please fill out the section below for any child under the age 18)*

NAME (last, first)	SOCIAL SECURITY NUMBER	DATE OF BIRTH		SEX ☐ M ☐ F
ADDRESS	CITY	STATE	ZIP	
RELATIONSHIP (check all that apply) ☐ **Mother** ☐ **Father** ☐ **Guardian** ☐ **Other** ☐ **Guarantor** (person financially responsible)	CELL PHONE	HOME PHONE		MARITAL STATUS
NAME (last, first)	SOCIAL SECURITY NUMBER	DATE OF BIRTH		SEX ☐ M ☐ F
ADDRESS	CITY	STATE	ZIP	
RELATIONSHIP (check all that apply) ☐ **Mother** ☐ **Father** ☐ **Guardian** ☐ **Other** ☐ **Guarantor** (person financially responsible)	CELL PHONE	HOME PHONE		MARITAL STATUS

The information provided above is complete and accurate to the best of my knowledge.

***Patient/Guardian Signature*____ *Date*____________________**



Patient Demographics

8.22.18 LE

PATIENT LABEL

Informed Consent for Acupuncture Treatment

I____hereby request and consent to the Performance of procedures which are within the scope of practice of acupuncture and oriental medicine, including but not limited to: acupuncture, moxibustion, cupping, electro acupuncture and gua sha scraping.

I have had an opportunity to discuss with the provider the nature and purpose of acupuncture.
I understand that the results are not guaranteed. There are some non-responders and some patients' symptoms will worsen initially prior to improving.

I understand and am informed that there are some risks to acupuncture and oriental medicine treatment, including, but not limited to: bruising, numbness or a mild tingling sensation near the needling sites that can last a few days. If moxibustion is performed, there is a small risk of mild burns, but care is taken to avoid this. There have been instances reported of spontaneous miscarriage and organ puncture, including pneumothorax. I understand acupuncture is permitted; however, if I suspect I am pregnant, I will immediately inform my provider. Certainly, while acupuncture is generally considered very safe, not all possible risks can be listed here. If I have what I consider to be an adverse reaction, I will inform my provider right away.

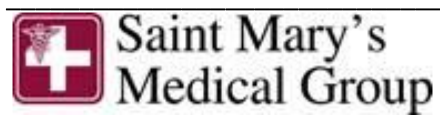
I have read and understand the above consent. I have also had an opportunity to ask the questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for the present condition and for any future condition(s) for which I seek treatment.

INTERPRETER INFORMATION: If the patient speaks a language other than English or is communicatively disabled, I have accurately and completely read the forgoing documents to _________________________ (name of patient/person legally authorized to give consent) in the patient's or patient's representative primary language. He/she understood all the terms and conditions and acknowledged his/her agreement thereto by signing this document in my presence.

____________________________	____________________________		
(SMMG Representative Name)	*(SMMG Representative Signature)*		
____________________________	____________________	_______________	*AM / PM*
(Cyracom ID number or Signature of onsite Interpreter)	*(Date)*	*(Time)*	

____________________________ __________________
Patient/Representative Signature Date

____________________________ __________________
Printed Name Witness



Informed Consent for Acupunture Treatment

PATIENT LABEL

PATIENT CONSENT & ACKNOWLEDGEMENT

PATIENT DOCUMENTS RECEIVED:

- Notice of Privacy Practices ______ (initial)
- Patient Financial Policy ______ (initial)
- Patient Portal Access and Use Agreement _____ (initial) **Email Address**: ________________________________

TREATMENT: I consent to and authorize Saint Mary's Medical Group and Saint Mary's Urgent Care Providers to examine and provide treatment.

PALLIATIVE CARE PATIENTS: I consent to and authorize Saint Mary's Medical Group Palliative Care to review my medical records, discuss goals of care, advanced care planning, assist with appropriate referrals/coordination of care and provide recommendations to my attending/referring physician as necessary.

RELEASE OF INFORMATION

- I authorize a copy of my record to be sent to my family provider or provider of referral following my appointment. **Preservation of Records Notice**: The Medical Group is authorized to dispose of patient's medical record after the 10th anniversary of the date the patient was last treated. For minor patients (less than 18 years of age) the medical group is authorized to dispose of patient's medical records after patient's 23rd birthday for those records which have been retained for at least 5 years or for any longer period provided by federal law.
- I authorize Saint Mary's Medical Group and Saint Mary's Urgent Care to speak to the named person (s) listed below regarding my medical condition(s) and care. Please be aware that we will not be able to speak to anyone other than the patient unless named below.

Name ________________________________ Relationship__________________________ Phone __________________

Name ________________________________ Relationship __________________________Phone __________________

PRESCRIPTIONS: I authorize Saint Mary's Medical Group and Saint Mary's Urgent Care and its designees to view my pharmaceutical history from external sources. Our practice uses Surescripts for this purpose.

PALLIATIVE CARE PATIENTS: Saint Mary's Palliative Care physicians do not prescribe medications. Medications may be filled at the discretion of your attending/referring physicians.

EMPLOYEE OR PROVIDER EXPOSURE TO BLOOD AND BODY FLUIDS: Patient understands that in the event an employee or provider is exposed to patient's blood or body fluids, a blood sample for HIV (AIDS), Hepatitis B and Hepatitis C antibodies will be obtained. Patient understands that the patient will be notified of testing. Patient understands that the results are confidential and will not be released to a third party without patient's permission except as permitted or required by law

INTERPRETER INFORMATION: If the patient speaks a language other than English or is communicatively disabled, I have accurately and completely read the forgoing documents to ________________________ (name of patient/person legally authorized to give consent) in the patient's or patient's representative primary language. He/she understood all the terms and conditions and acknowledged his/her agreement thereto by signing this document in my presence.

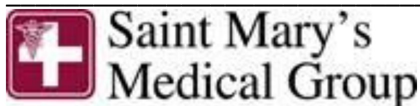
_____________________________ ______________________________ ______________ _______ AM / PM

(SMMG Representative Name) (SMMG Representative Signature) (Cyracom ID #) (Time)

By signing below, I agree to abide by the terms and conditions outlined above including the patient documents received.

Patient/Representative Name (Please Print) ____ Date _______________

Patient/Representative Signature ____ Date _______________



Patient Consent & Acknowledgement

PATIENT LABEL

PARENT CONSENT FOR TREATMENT OF MINOR CHILD
PARENT OR LEGAL GUARDIAN NOT PRESENT

In the event that the parent(s) or legal guardian(s) of the patient named below is/are not available at the time of service and at the sole discretion of the Provider of Care and/or Management, this form may be used to document authorization for treatment received by phone if patient is accompanied by an authorized person 18 years or older.

Parent or person having legal custody/legal guardianship authorizes:

____ __________________
(name of person accompanying patient) (*date of birth)*

To consent for treatment for ________________________________ __________________
(patient's name) *(patient's Date of Birth)*

We spoke with ____ _________________
(parent or legal guardian name) *(date of birth)*

Identification on file ____
(*indicate relationship)*

at (______) _______ - _________ *(number called)* at ________ am / pm *(circle one)*

We further acknowledge that we obtained verification of the identity of the patient's parent or legal guardian using established standard operating procedure.

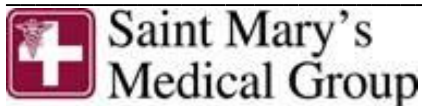
Verified all information as above. Verbal consent obtained

Staff Member #1: Print Name____

Signature_____________________________________ Date______________

Staff Member #2: Print Name____

Signature_____________________________________ Date______________



PATIENT LABEL