Please complete in black or blue ink

NAME: _____BIRTHDATE:_____AGE: _____

ADDRESS: _____CITY, STATE, ZIP: _____

MARITAL STATUS: M S W D PRIMARY PHONE: (____)_____

ALTERNATE PHONE: (____)_____ SS#: _____

EMPLOYER: _____ POSITION: _____

EMPLOYER PHONE: _____ LENGTH OF EMPLOYMENT: _____

RESPONSIBLE PARTY (person holding the insurance) - OR SPOUSE INFORMATION:

NAME: _____ BIRTH DATE: _____ RELATION SHIP: _____ SS#: _____

EMPLOYER: _____ EMP PHONE: _____ LENGTH OF EMPLOYMENT: _____

OTHER INFORMATION:

NEAREST LIVING RELATIVE (not living with you) _____ PHONE: _____

REFERRING/FAMILY DR (circle one) _____ PHARMACY: _____

INSURANCE*: (This section only needs to be completed IF you do not have a card for us to scan)*

MEDICARE #: _____MEDICAID #: _____ HMO?:_____

1ST INSURANCE: _____ ADDRESS: _____

PHONE: _____ POLICYHOLDER: _____ DATE OF BIRTH: _____

RELATIONSHIP: _____ GROUP#: _____ POLICY #: _____

2nd INSURANCE: _____ ADDRESS: _____

PHONE: _____ POLICYHOLDER: _____ DATE OF BIRTH: _____

RELATIONSHIP: _____ GROUP#: _____ POLICY #: _____

Please note: Our system does not automatically bill 2nd insurances so you may need to call us and remind us to do so. We will make every effort to take care of this for you in a timely manner. If you have 2 insurances and are having surgery ---you will be responsible for contacting secondary insurance for prior authorizations. We will call your PRIMARY insurance for INPATIENT procedures only.

PLEASE READ AND SIGN THE REVERSE SIDE

JOHN R. CLARK, M.D, P.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND FINANCIAL RESPONSIBILITY/ASSIGNMENT AGREEMENT

John R. Clark, M.D, P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

John R. Clark, M.D, P.C. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others. John R. Clark, M.D, P.C. may also mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to review the Notice of Privacy Practices prior to signing this consent. John R. Clark, M.D, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to John R. Clark, M.D, P.C., Privacy Officer at 600 S. Lakeview Ave. Ste 207, Sturgis, MI 49091.

I have the right to request that John R. Clark, M.D, P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to John R. Clark, M.D, P.C.'s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, John R. Clark, M.D, P.C. may decline to provide treatment to me.

I assign Dr. Clark all payment for medical services rendered to me and/or my dependents. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT FOR SERVICES RENDERED (except for contracted HMO benefits). I further understand that my biopsies or lab specimens that are obtained in this office will be sent to Sturgis Hospital or other lab for reading and this information will be disclosed to them for billing purposes. I am also responsible for payment to those entities for services rendered. I am aware that Dr. Clark has a credit and collection policy that will be enforced upon non-payment of my account. And that I will be responsible for any service charges associated with the collection proceedings if I do not pay my balance in a timely manner.

Medicaid is accepted for payment in limited circumstances. Valid Medicaid card MUST be presented at the TIME OF SERVICE. If a valid Medicaid card is not presented at the time services are rendered, the patient is responsible for all charges incurred on that date. Dr. Clark dos not bill retroactively.

Is there anyone at your home that we should NOT leave a message with? Please list names:

_____ _____ _____ _____

_____ _____

Signature of patient or legal guardian Date

I HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW THE PRIVACY POLICIES AND CREDIT, COLLECTIONS, AND OFFICE GUIDELINES FOR JOHN R. CLARK, M.D., P.C.

_____Patient initials