WYBENGA FAMILY HEALTHCARE
564 N. MEMORIAL DRIVE • PRATTVILE, AL 36067
Martin Wybenga, M.D.
Amy Wybenga, CRNP
Jenny Mann, CRNP

Consent for Treatment: I, the undersigned, consent to the care and treatment by the attending physician, his associates, or Assistants. The treatment may include, but is not restricted to medications, (oral, injectable, or other) anesthesia, surgical and invasive procedures, lab, x-ray, or other studies that may be helpful in the performance of the patient's care. I further consent to the above care and treatment to be provided today and in the future for myself or my minor ward. This consent may be revoked at any time upon written notice to this office. I understand that specimens given or results received on behalf of an employer's drug screen are considered the property of the employer.

Authorization for Release of Medical Records: I hereby authorize the release of any or all medical record, including psychiatric, drug, alcohol, HIV, and substance abuse records, to physicians or agencies involved in the patient's care, insurance carriers or those involved in the performance of quality assurance.

Assignment of Benefits and Guarantee of Account: I accept full financial responsibility for any services rendered and I understand the payment of charges in this office is due at the time of service. I understand credit and billing services are not routinely provided by this office and should billing for serviced become necessary, a service charge may be applied. I also understand that charges not covered by my insurance, or charges not covered by any government benefit, and insurance not accepted by this office remains my responsibility. I am responsible for any co-pays, deductibles, and charges not allowed and will make payment for these services to this office. In the event the payment is received from another source for services provided, I authorize application of the proceeds received from this source upon any other medical bills of mine or any member of my family whose bill I would be legally responsible that has not been paid in full. I further recognize that if payment is made directly to me by an insurance company, the amount received up to the amount of all medical bills for services provided is the property of this office and should be paid here immediately. I further understand that this office will attempt to collect assigned insurance benefits for the period of thirty to sixty days after the date of service, but at which time payment of the full amount due will be my responsibility. All accounts with a balance due at the end of sixty days are considered delinquent. If for any reasons the account should become delinquent, I agree to pay all collection costs including attorney fees.

Patient Acknowledgment Form: I understand that this office has available a full Privacy Policies Manual that is available to me if I would like to review it. My signature indicates that I agree to allow them to use and disclose the patients's personal health information to carry out treatment, payment, and health care operations. I understand that instructions for revoking this consent of patient's personal health information is outlined in this manual.

My signature below indicates that I have read and understand all of the above information on this page and that if I ask I may review this office's Privacy Policies Manual.

Signature_____ Date_____

MEDICAL INFORMATION RELEASE

Your medical information will only be given to you unless you indicate that we may give your medical information to the following people (ex: spouse, children, parents)

_____

_____

_____

_____yes, we may leave information on your voice mail or answering machine.

Signature_____ Date_____

_____

Relationship to patient if this form is signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

PATIENT INFORMATION

PLEASE **PRINT** CLEARLY AND FILL IN ALL INFORMATION. **PLEASE SIGN BOTTOM OF FORM.**

PERSONAL

FULL NAME _____ NICKNAME / ALIAS _____

DATE OF BIRTH_____ AGE _____ SEX _____ MARITAL STATUS (CILCLE ONE) S M W D

SOCIAL SECURITY NUMBER _____ EMAIL ADDRESS_____

STREET _____ CITY_____ STATE_____ ZIP_____

HOME PHONE:_____ WORK PHONE:_____ CELL PHONE:_____

REASON FOR VISIT_____ REFERRED BY_____

EMPLOYER_____ ADDRESS_____

OCCUPATION_____

I HEREBY AUTHORIZE INFORMATION TO BE GIVEN TO (I.E. FAMILY MEMBER ETC): _____

PREFERRED PHARMACY AND PHONE#:_____

CONTACTS/REFERENCES

NAME OF SPOUSE OR PARENT_____ RELATION_____

SOCIAL SERCURITY NUMBER_____ HOME PHONE_____

STREET_____ APT#_____ CITY_____ STATE_____ ZIP_____

EMPLOYER_____ ADDRESS_____

OCCUPATION_____ WORK PHONE_____

NAME OF THE NEAREST RELATIVE OR FRIEND NOT LIVING WITH PATIENT_____

RELATION TO PATIENT _____ HOME PHONE_____

INSURANCE

NAME OF PRIMARY INSURANCE CARRIER_____

IDENTIFICATION NUMBER_____ GROUP NUMBER_____

NAME OF SUBSCRIBER_____ DOB OF SUBSCRIBER_____

RELATION TO PATIENT_____ SSN OF SUBSCRIBER_____

NAME OF SECONDARY INSURANCE CARRIER_____

IDENTIFICATION NUMBER_____ GROUP NUMBER _____

NAME OF SUBSCRIBER_____ RELATION TO PATIENT_____

AUTHORIZATION TO RELEASE INFORMATION

TO FACILATE POSSIBLE FUTURE FILING OF INSURANCE CLAIMS. PLEASE READ AND SIGN THE FOLLOWING AUTHORIZATION. NATURALLY, IF YOUR SERVICES ARE PAID IN FULL BY YOU, THE FOLLOWING AUTHORIZATION WOULD NOT BE USED BUT WOULD BE KEPT ON FILE FOR EVENTS WHEN IT MIGHT BE NEEDED. AUTHORIZATION OF BENEFITS/AUTHORIZATION TO RELEASE INFORMATION/STATEMENTS OF UNDERSTANDING OF FINANCIAL RESPONSIBILITY: I, the undersigned, hereby transfer, assign and convey to Wybenga Family Health Care, Inc., its authorized employees and agents, all my rights, title and interest in and to any and all medical reimbursement benefits under my insurance policy(ies) with _____ Insurance Company(ies). This assignment of interest is limited to only those charges incurred by me and not paid in full by me to Wybenga Family Health Care, Inc. In furtherance of such assignment, I hereby authorize Wybenga Family Health Care, Inc., to release any medical information about myself necessary for the purpose of filing such claims for payment or reimbursement.

I understand and acknowledge that I am financially responsible to Wybenga Family Health Care, Inc. for any charges incurred by me, for my health care, and not paid by my insurance company. I further understand I must timely settle my account with Wybenga Family Health Care, Inc. I further acknowledge and understand that in the event that I am default of any payment owed to Wybenga Family Health Care, Inc. and it becomes necessary, at the discretion of Wybenga Family Health Care, Inc. to place this account with a collection agency or attorney, that I will be responsible for any and all cost, expenses or fees such as collection agency or attorney.

PATIENT SIGNATURE_____ **DATE**_____