HealthCARE Express®

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your privacy is important to Healthcare Express. As a result, we ask you to complete the following authorization related to your personal health and health-related benefits.

I hereby authorize use and disclosure of protected health information (PHI), as described below.

This Authorization relates only to the PHI of:

PATIENT NAME: _____ Last four digits of Social Security Number: _____

I hereby authorize Healthcare Express to release information about my account at Healthcare Express to the following people:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

I hereby authorize Healthcare Express to release information about my medical treatment (PHI) to the following people:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

I have read and understand the following statements about my rights:

A.) I may revoke this authorization at any time by giving written notice to Healthcare Express. I understand that my revocation will not affect any use or disclosure of my PHI that was made in reliance on the authorization before I revoked it.

B) My health provider cannot require me to sign this authorization in order to be eligible for services or treatment.

C) It is possible that the persons who receive information based on this authorization may disclose it to others and as a result the information may no longer be protected by federal privacy rules.

D) This Authorization for my personal health information does not apply to the release of the same information for any spouse or child that I may cover on my medical benefits or account at Healthcare Express. I understand that my spouse or child over 18 must provide independent Authorization for release of their personal PHI.

I acknowledge that I have received and signed a copy of this authorization.

_____ _____
Patient or legally authorized individual signature **Date**

Please complete other side

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AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

Patient Name: _____ Date of Birth: _____
Patient Mailing Address: _____

Preferred Pharmacy if necessary: _____

May leave detailed message on telephone answering machine at home # (____) _____

May leave detailed message on voicemail at work # (_____) _____

May leave information with Spouse (name): _____

May leave information with other family member (name): _____

May leave detailed message on cellular phone # _____

May leave detailed message at a different location # _____

May send detailed message by email to: _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify HealthCARE Express should I change one or more of the telephone numbers listed above OR any one of the contact names.

_____ _____
Patient or legally authorized individual signature **Date**

Please complete other side

PATIENT INFORMATION	
SSN:	HOME PHONE:
FIRST NAME:	CELL PHONE:

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LAST NAME:	EMAIL ADDRESS:
MIDDLE NAME:	HOW DID YOU HEAR ABOUT US?
DATE OF BIRTH:	MARITAL STATUS:
SEX: M OR F	EMPLOYER:
MAILING ADDRESS:	EMPLOYER PHONE NUMBER:
CITY:	RACE: HISPANIC/LATINO Y OR N
STATE: ZIP CODE:	PREFERRED LANGUAGE:

EMERGENCY CONTACT:		
NAME:	RELATIONSHIP:	PHONE NUMBER:

PERSONAL INSURANCE COVERAGE			
Primary Insurance:		**Secondary Insurance**:	
NAME OF POLICY HOLDER:		NAME OF POLICY HOLDER:	
MEMBER ID NUMBER:		MEMBER ID NUMBER:	
GROUP NUMBER:		GROUP NUMBER:	
POLICY HOLDERS SSN:	DOB:	POLICY HOLDERS SSN:	DOB:
RELATIONSHIP TO PATIENT:		RELATIONSHIP TO PATIENT:	

GUARANTOR'S INFORMATION (If patient is under the age of 18):			
FIRST NAME: LAST NAME:		DOB: SSN:	
MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:

CONSENT FOR TREATMENT: Healthcare Express and their employees evaluate and treat the above patient for medical complaint and illnesses. This includes taking of medical information, evaluation by physical examination, obtaining of bodily fluids for laboratory testing, obtaining of X-rays for diagnosis, the administration of medications for treatment, and any other treatment or evaluation that may be necessary. If, at any time, I do not wish to have these services rendered, I may state so and they will not be provided, but an AMA form may need to be signed by the patient. All of my information will remain confidential. I acknowledge that I have been offered a copy of Healthcare Express Notice of Privacy Practices. _____initials

ASSIGNMENT OF BENEFITS: I authorize the release of any medical information and payment of medical benefits to Healthcare Express for services necessary to process this claim and any future claims. I agree to be responsible for any deductible, co-insurance, co-pay, or any other balance not paid by my insurance. _____initials

FINANCIAL POLICY: We are committed to providing you with the best possible medical care; if you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment of professional services.

PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE: Co-payment will be collected before you are seen. Payment can be made by cash, check or credit card. If you have insurance that we do not participate with, our office will be happy to file the claim upon request; however, payment in full is expected at the time of service. If you have questions about your insurance coverage, we will be happy to assist you. Specific coverage issues should be directed to your insurance company. It is however, understood and agreed that the Responsible Party is responsible for all monies due for services rendered in the event insurance does not pay for these services. ALL CHARGES ARE AN ESTIMATE AND FINALIZED WHEN YOUR INSURANCE COMPANY PROCESSES YOUR CLAIMS. _____initials

A 20% DISCOUNT has been applied to the total bill for patients paying self-pay prices at the time of service. This discount does not apply to patients with insurance. _____initials

If laboratory tests must be sent to an outside source for further evaluation, the responsible party understands they will be responsible for charges from that facility. _____initials

When visiting our facilities After hours, nights and weekends a fee may be applied to the charges billed to your insurance company which is reasonable and customary in our contracts. ____initials

Contact: Providing your email and cell phone number will automatically register you for these forms of communication. Please let the front desk know if you would like to change these settings.

NOTE: It is company policy to run your check by EFT or your credit card. For private pays (no insurance) all charges for the visit are due before you are seen. Please note that you may have a balance at the end of your visit, which must be paid before you exit the clinic

By signing below, I agree that I have read and understand the terms of this agreement.

PATIENT or Legally Authorized Individual Signature **DATE**

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CONSENT TO RELEASE PHARMACY RECORDS

By my signature below, I acknowledge and voluntarily consent to release to HealthCARE Express, information related to pharmacy records that shall include but not limited to, prescription history, immunization records, pathology reports and laboratory reports.

I further understand and agree that this release shall apply to multiple and unaffiliated health care providers, insurance companies and pharmacy benefit managers and that such information shall be viewable by providers and staff of HealthCARE Express.

By my signature below, I expressly acknowledge that information obtained under this RELEASE may be considered as Protected Health Information ("PHI") and may include information related to HIV/AIDS, mental health, drug/alcohol use and treatment information and I hereby release such information to HealthCARE Express for diagnosis and treatment and health care services.

I understand the right to revoke this authorization, at any time, by sending a written revocation notice to HealthCARE Express at the following address:

HealthCARE Express
3515 Richmond Road
Texarkana, TX 75503

Any revocation that is received shall not apply to the records that have already been received by HealthCARE Express under this RELEASE.

Following my signature, I understand that I may receive a copy of this RELEASE upon request to HealthCARE Express.

I certify that I have read this form, or it has been read to me and I understand the contents of this RELEASE.

Date: _____

Print Name (Patient): _____

DOB: _____

Signature of Patient/Legally Authorized Representative: _____

Relationship to Patient (if Patient not signing): _____

For patients requiring translation or verbal reading of this document, the person reading or translating should document and sign below:

Reader/Translator Signature: _____ Date: _____

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A photocopy of this RELEASE shall be as valid as the original.