Name of Patient _____
First Name *Middle Name* *Last Name*

Address _____ **Apt** _____

City _____ **State** _____ **Zip** _____

Home Telephone _____ **Alt. Number** _____

Date of Birth _____ **Sex** _____ **Marital Status** _____

Social Security # _____

EMPLOYER INFORMATION

Employer Name _____ **Work Telephone #** _____

Address _____ **Supervisor Name** _____

Work Fax #: _____

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS: I understand that I am financially responsible and agree to pay all of COMP's charges that are not paid by or billed to insurance or any other third party payer. I authorize payment directly to COMP for all benefits otherwise payable to me, not to exceed COMP's regular charges.

RELEASE OF INFORMATION: I authorize COMP and my practitioner(s) to release [verbally or in writing] confidential medical, psychiatric and/or psychological information in my medical record to my employer (Workers' Compensation only) and to any person or entity which may be liable to me, COMP, or my Practitioner(s) for charges for this treatment, and for quality management/utilization review, discharge planning, transfer and follow-up purposes. I understand that following the release of this information COMP and its Practitioner(s) cannot control its confidentiality. I understand this release of information is subject to revocation at any time except to the extent that COMP or Practitioner(s) have already taken action in reliance on it. If not previously revoked in writing, this consent will terminate on (1) year from the date this agreement issigned.

CONSENTS AND DISCLOSURES: I hereby voluntarily agree to diagnostic procedures and medical and surgical treatment which may be administered to or performed on me under the general or special instructions of the attending Practitioner's care and service or the Practitioner's designee(s). I further understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks. No guarantees have been made to me as to the results of my treatment with COMP. I understand that COMP encourages me to ask questions and voice concerns about medical care or services and that asking questions or voicing my concerns will not compromise my care. NOTE: A copy of this agreement may be used with the same effectiveness as an original.

BY SIGNING BELOW I HEREBY CERTIFY THAT I HAVE READ THIS AGREEMENT AND/OR THAT IT HAS BEEN FULLY EXPLAINED TO ME, THAT I UNDERSTAND ITS CONTENTS, AND THAT I AM THE PATIENT, OR A PERSON DULY AUTHORIZED TO EXECUTE THIS AGREEMENT AND ACCEPT ITS TERMS.

Signature of Patient/
Responsible Party _____ **Date** _____

Relationship (If other than patient) _____

Patient HIPAA Acknowledgement and Consent Form

Patient Name: _____

Date of Birth: _____

(Patient/Representative initials) Notice of Privacy Practices.

_____ **I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.**

(Patient/Representative initials) Release of Information.

_____ **I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.**

- Healthcare information regarding a prior admission(s) at other CMOP affiliated facilities may be made available to subsequent CMOP-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"
I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship