



STAR CITY
MEDICAL INC.

NEW PATIENT INFORMATION

Name: _____
FIRST MIDDLE LAST SUFFIX

Address: _____
NO. STREET CITY STATE ZIP CODE

Date Of Birth: ____ / ____ / ____ SSN: _____

Marital Status: Married Divorced Single Sex: M F

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Position: _____

Email: _____ Pharmacy: _____ Location: _____

How did you find about us? _____

RESPONSIBLE PARTY (IF DIFFERENT THAN ABOVE)

Name: _____
FIRST MIDDLE LAST SUFFIX

Street Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____

Date Of Birth: ____ / ____ / ____ SSN: _____ Sex: M F

Home Phone: _____ Work Phone _____

Employer: _____ Position: _____

Do you have a living will? _____ Are you an organ donor? _____

Do you have a religious preference? _____ Have you ever served in the military? _____

What is the highest educational level you have completed? _____

Do you:

Smoke cigarettes? _____ No. of packs per day? ____ No. of years? ____ Use smokeless tobacco? _____

Drink alcohol? _____ How many drinks per week? _____ How many years? _____



STAR CITY
MEDICAL INC.

MEDICAL HISTORY

Allergies: _____

Current Medications: _____

Please list any past medical problems:

Please list past surgical procedures: _____

Please list any family medical history: _____



PATIENT ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I hereby authorize Star City Medical to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to Star City Medical of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Patient's Signature (or Responsible Party): _____ Date: _____

NOTE OF PRIVACY PRACTICES (HIPPA)

I acknowledge that Star City Medical has provided me a copy of its Notice of Private Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

Patient's Signature (or Responsible Party): _____ Date: _____

SPECIFIC INFORMATION REQUEST

(Complete this section if you would like medical information from Star City Medical to be released to other health care providers)

Provider's Name: _____ Phone No.: _____

Provider's Name: _____ Phone No.: _____

Provider's Name: _____ Phone No.: _____

CONSENT FOR USE OR DISCLOSURE OF PATIENT INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby consent to Star City Medical using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for healthcare services rendered to me or to carry out Star City Medical's healthcare operations. I also consent to Star City Medical using or disclosing my protected health information for treatment activities provided by another provider or entity. I further consent to the disclosure of my protected health information in order for another provider or healthcare entity to conduct healthcare operations including quality assessment and reviewing the competence of healthcare professionals.

Patient's Signature (or Responsible Party): _____ Date: _____



You agree, in order for us to service your account or to collect any amounts you may owe us, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/we have read this disclosure and agree that our collection agency may contact me/us as described above.

Signature: _____

Date: _____



CONSENT TO SHARE CONFIDENTIAL INFORMATION
To be valid, this form must be filled out COMPLETELY

Patient's Legal Name: _____ Birth Date: _____

I HEREBY AUTHORIZE STAR CITY MEDICAL TO SHARE:

Any and all medical information

Only appointment dates and times

Other information (specify) _____

WITH THE FOLLOWING PERSONS:

(1) FULL NAME: _____

RELATIONSHIP: _____

PHONE: _____

(2) FULL NAME: _____

RELATIONSHIP: _____

PHONE: _____

* (I understand that I may cancel this consent at any time, but that canceling it will not affect any information that has already been released.

* I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

Signature: _____ Date: _____



COLLECTIONS POLICY

Collection Agency/Attorney Fees–In the event that your account is turned over to a collection agency or attorney, you agree that you will be responsible for a collection fee equal to 33.3% of the outstanding balance due on the date the account is turned over for collection.

Collection Costs - In the event that the account becomes delinquent and is necessary to expend costs for the collection of the account, you understand that you will be responsible for the costs. These costs could include court costs for filing suit against you.

Patient/Responsible Party Signature: _____

Date: _____



CANCELLATION AND NO SHOW POLICY

1. Cancellation/No Show for Scheduled Appointment:
2. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting a much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not canceled at least 24 hours in advance you will be charged \$60.00 for a New Patient Appointment and \$35.00 for an established patient; this will not be covered by your insurance company. This appointment will also be marked as a No Show since adequate cancellation notice was not given. We will limit the number of No Shows or late cancellations allowed per patient. If you are a No Show (3) times, we will no longer schedule appointments for you at our practice.
3. Late Arrival for Scheduled Appointments:

We understand that delays can happen; however we must try to keep the other patients and doctors on time. If a patient arrives 15 minutes past their scheduled time we will have to reschedule the appointment.

Collection Costs - In the event that the account becomes delinquent and is necessary to expend costs for the collection of the account, you understand that you will be responsible for the costs. These costs could include court costs for filing suit against you.

Printed Name: _____

Patient/Responsible Party Signature: _____

Date: _____



Star City Medical, Inc and Weigh Station, Inc are separate entities and medical clinics. Your records will be stored in a unified HIPPA compliant electronic medical records system that holds both patient lists under the guardianship of Dr. Justin Lindsey. Records can be accessed by the shared staff on an as needed basis in compliance with the Health Insurance Portability and Accountability Act.

Agree and understand.

Signature: _____

Date: _____