# LOWRY MEDICAL CLINIC

## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for LOWRY MEDICAL CLINIC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. (The Notice of Privacy Practices provided by LMC describes such uses and disclosures more completely and is continually located in the waiting room at LMC.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. LMC 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 Robin Lowry or Cindy Reeves at LOWRY MEDICAL CLINIC.

With this consent, LMC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, LMC may mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements.

With this consent, LMC may e-mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements. I have the right to request that LMC restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. 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 allow LMC to use and disclose my PHI to carry out treatment, payment, and health care operations.

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, or later revoke it, LOWRY MEDICAL CLINIC may decline to provide treatment to me.

Signed by: _____ _____ _____

Signature of Patient or Legal Guardian  Date  Relationship to Patient

_____ _____

Print Patient's Name  Print Name of Legal Guardian, if applicable

***** I agree my medical information may be disclosed the following:

(1) _____ (2) _____

Signed by: _____ _____ _____

Signature of Patient or Legal Guardian  Date  Relationship to Patient

_____ _____

Print Patient's Name  Print Name of Legal Guardian, if applicable

**Lowry Medical Clinic**
**Slater B. Lowry, M.D.**

# Patient Information Form

Please print all information in the spaces provided, Be sure to complete and sign the statement on the back of this form.

Last Name _____ First Name _____ M.I. _____

Home Address (Street, City, State, Zip Code) _____

_____

Home Phone _____ Work Phone _____

Employer Name and Address _____

Social Security Number _____ Date of Birth _____

Primary Insurance
Company Name and Phone Number _____

Billing Address _____

Name of Insured and Relation to Patient _____

Insured's ID Number _____ Group Number _____

Secondary Insurance
Company Name and Phone Number _____

Billing Address _____

Name of Insured and Relation to Patient _____

Insured's ID Number _____ Group Number _____

Name and Phone Number of person to contact in the case of an emergency _____

_____

I hereby authorize payment of medical benefits billed to my insurance to LMC. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance.

I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered.

I will pay by (check one) ❑ cash ❑ check ❑ credit card.

_____ _____

Signature of Patient or Guardian Date

**LMC**

LOWRY MEDICAL CLINIC
362 Park Creek Drive
Columbus, MS 39705

***OUR FINANCIAL ROLICY****

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies. Please initial each line and sign after reading. Thank You.

_____ 1. Payment is due at the time of service unless arrangements have been made in advance of your time of service. We accept* Visa and MasterCard only.*

_____ 2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we file your insurance claim if you assign the benefits to the doctor - in other words, if you agree to have your insurance company pay the doctor directly. *If your insurance company does not pay the practice, within a reasonable period, we will have to look to you for payment.* If we later receive a check from your insurance provider, we will refund any overpayment to you.

_____ 3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment at the time of your visit.

_____ 4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.

_____ 5. Not all insurance plans cover all services. In the event that your insurance plan determines a service is "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

_____ 6. If your balance is 90 days past due it will be turned over to collections. You, the patient, will be responsible for any or all collection and legal fees due to this past due account. An interest fee of $30.00 or 30% (whichever is greater) will be added to the balance before it is sent to the collection agency.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of Patient (or responsible party, if minor) Date

_____

Please Print the Name of the Patient

7/24/13