FONTICIELLA MEDICAL CLINIC
1000 W KINGSHIGHWAY STE 12
PARAGOULD AR 72450
PHONE (870) 236-6930 FAX (870) 239-8065

Patient Name: _____ Date of birth:_____ _____

Marital Status: Single Married Divorced Widowed Social Security Number: _____

Ethnicity/Race: _____ Primary Language: _____

Mailing Address: (where you receive mail) _____ _____

_____

Home Phone: _____ Cell: _____Work Phone: _____

Message Number: _____ Email Address: _____

Employer Name & Address _____

Emergency Contact Name/Phone #/Relationship

_____

Pharmacy Name:_____ Mail order pharmacy:_____

PLEASE PROVIDE YOUR INSURANCE CARDS TO THE FRONT DESK AT THIS TIME

Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to Fonticiella Medical Clinic for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles, non-covered services are due at the time of service. Statement fees and charges may apply.

Signature of Responsible Party: _____ Date: _____

Responsible Party (if minor): _____ Date: _____

Records Release

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party : _____Date: _____

Responsible Party (if minor): _____Date: _____

E prescribing Program

E prescription is a way for doctors to electronically and accurately, error free and understandably send prescriptions to/from pharmacies.

Allows the health care provider to send and receive electronic notice from /to the pharmacies.

Signature of Responsible Party: _____Date:_____

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I give permission to Fonticiella Medical Clinic, Inc. and any or all its providers to share private medical information about me which includes all names, address, and phone numbers . I also give permission to have these people listed in my circle of care.

_____
_____
_____
_____
_____

I understand:

- **State and Federal privacy laws protect my records.**
- **My records can be released only if I give my written permission or if the law requires it.**
- **I can refuse to sign this form, if I refuse, information will not be released to the person named above, unless the law requires it.**
- **I can stop this consent to release information at any time by writing to Fonticiella Medical Clinic ,Inc. This written notice will not affect information the agency has already released.**
- **This consent will end one year from the date I signed it.**
- **If a family member is having access to your medical records for use of your patient portal please give consent stating that you allow your family member to have access to your medical records under your patient portal .**

Patient Name _____ SS#_____

Patient Signature _____

Patient Portal Consent --(if not patient) who you give consent to have access to your patient portal

_____please list the email below under the email address you wish to have activated under your patient portal, which will give direct access to your medical records electronically.

Date _____

Address _____

Telephone Number_____ or _____

Email Address _____

Witness: _____ Date: _____