CATALYST
Medical Clinic PA

PATIENT INFORMATION

Please PRINT. All information will be confidential. **Date Completed:**_____

Patient Name_____
LAST NAME FIRST NAME M.I.

☐MALE ☐FEMALE Birth Date: _____ Soc Sec #:_____

Address: _____ Home Phone: _____

City/State/Zip: _____ Cell Phone: _____

Employer:_____ City:_____ Work Phone: _____

PLEASE COMPLETE: **Preferred Language:**_____ **Race:** _____ **Country of Birth:**_____

Check Appropriate Box: ☐**Single** ☐**Married** ☐**Divorced** ☐**Widowed** ☐**Separated**

☐ **Minor (Parents/Guardian Name):** _____

Person to contact in case of emergency: _____ **Phone:** _____

Billing Information: (Fill out only if different from above):

Responsible Party Name: _____ Relationship to Patient:_____

Address:_____ City/State/Zip:_____ Home Phone:_____

INSURANCE POLICY HOLDER:

Policy Holder's Name:_____ Birth Date:_____

Relationship to Patient:_____ Social Security #:_____

The above protected health information will be used by Catalyst Medical Clinic, P.A. or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. Furthermore, my signature below authorizes Catalyst Medical Clinic, P.A. to provide medical treatment and advice in a fashion consistent with the contemporary standard of care. **Notice of Privacy Practices:** You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent. You may request a restriction on the use or disclosure of your protected health information. Catalyst Medical Clinic, P.A. may not agree to restrict the use or disclosure of your protected health information. If Catalyst Medical Clinic agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards. You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. Catalyst Medical Clinic, P.A. reserves the right to modify the privacy practices outlined in the notice. I also authorize payment of insurance benefits and Medicare directly to Catalyst Medical Clinic, P.A. I understand that I am financially responsible for all co-payments and any charges not paid by insurance. A photocopy of this authorization shall be as effective and valid as the original.
I authorize Catalyst Medical Clinic, P.A. to release to the Social Security Adm. and Health Care financing (if applicable), any information needed for this or a related Medicare claim. This shall be valid from the above completion date thru my lifetime.

I understand and agree that my insurance company may share my past, current and future health and account records with Catalyst Medical Clinic, P.A. about services I have received from Catalyst Medical Clinic, P.A. and other care providers unrelated to Catalyst Medical Clinic, P.A. These records may be used by Catalyst Medical Clinic, P.A., my certified medical home, as needed to manage or coordinate my care and to improve the quality of that care. If I do not agree to this, I will initial below.

_____My insurance company may not release any identifiable health records from providers unrelated to Catalyst Medical Clinic, P.A. for the purposes described above.

X_____ _____

Signature of patient (or parent if minor) **Date Signed**