JJMA
Jones & Jones Medical Associates

Patient Information Sheet

Date:_____

Last Name:_____ **First Name:**_____ **MI:**__ **DOB:**_____ **Sex:** M/F __

Marital Status: __Married __ Single __Widowed/Widower **Ethnicity:** ___Hispanic/Latino __NonHispanic/Latino

Preferred Language:_____ **Race:** __ White __Black/African American __Native Indian Alaskan __Asian

__Native Hawaiian/Pacific Islander _____Other __Declined To Answer **SSN#**_____

Email:_____ **Drivers License:**_____

Occupation:_____ **Employer:**_____

Responsible Party:(If a minor or full time student)_____ **Relationship:**_____

Patient Information

Mailing Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Phone#_____ **Work Phone #**_____ **Mobile Phone#**_____

Emergency Contact Name:_____ **Emergency Contact #**_____ **Relationship:**_____

Do You Have Medical Insurance? __ Yes __ No **Primary Insurance:**_____ **Policy#**_____

Secondary Insurance:_____ **Policy #**_____ **Subscriber SSN #**_____

Subscriber Name:_____ **D.O.B**_____ **Other Coverage:**_____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance of your prior Consent. Jones & Jones Medical Associates provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- Jones & Jones Medical Associates has a Notice of Privacy Practices and the patient has the opportunity to review this notice.
- Jones & Jones Medical Associates reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information, but Jones & Jones Medical Associates does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- Jones & Jones Medical Associates may condition treatment upon the execution of this consent.

My signature below authorizes Jones & Jones Medical Associates to bill my Insurance for all medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance company. I authorize release of my medical information to my Insurance carrier and it's agents. Additionally my signature provides willing consent to any procedures that may be required, including emergency treatment or services. I acknowledge receipt of Jones & Jones Medical Associates privacy policy, and have read, or have had it read to me. I understand and agree to the provisions and terms listed above.

Signature Of Patient or Responsible Party:_____
Date:_____

Witness:(Practice Representative): _____
Date:_____