Mercy Wellness Clinic Patient Authorization

Please read, initial and sign below:

(Initial)_____ **Credit Card on File:** I understand that by providing my current credit card information to Mercy Wellness Clinic that I am authorizing it to be charged for any balance remaining after all insurances on file have been billed and processed.

(Initial)_____ **Assignment of Benefits:** I hereby authorize payment directly to Mercy Wellness Clinic, for medical benefits otherwise payable to me. I authorize my insurance company to disclose to Mercy Wellness Clinic, information regarding my insurance coverage, including, but not limited to verification of my examination and/or treatment to my insurance company and/or third-party payor.

(Initial)_____ **Privacy Policy:** I acknowledge that I received, reviewed, and agree to comply with the Mercy Wellness Clinic Privacy Policy.

(Initial)_____ **Consent to Treat:** I have the legal right to consent to medical and surgical treatment for myself. I voluntarily authorize and consent to the medical care, treatment and diagnostic tests that providers of Mercy Wellness Clinic believe are necessary for myself. I understand that by signing this form, I am giving permission to the doctors, nurses, and other healthcare providers to provide treatment for myself as long as I am a patient at Mercy Wellness Clinic.

(Initial)_____ **E-Prescribing:** I voluntarily authorize Mercy Wellness Clinic to allow E-Prescribing for my prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medical dispense history so long as I am a patient at this office.

(Initial)_____ **Recording/Photo Policy:** Mercy Wellness Clinic does not permit recording devices in the exam room or common areas. Our staff and other patients have the right to their image and likeness; therefore, we do not allow recording or photos of any kind during the visit. I understand the policy and agree to comply.

(Initial)_____ **Phone Messages:** I give my permission for Mercy Wellness Clinic to leave detailed phone messages when I am unable to answer the phone.

(Initial)_____ **Annual Wellness/Physicals:** I understand that if I am here for an annual wellness exam/physical that it is covered by insurance. I understand that I may be billed for a regular office visit if I discuss other issues with the doctor that are not related to my annual physical.

(Initial)_____ I understand I can withdraw my consent at any time by contacting Mercy Wellness Clinic in writing at 18568 Forty Six Parkway, Spring Branch, TX 78070. Withdrawal may result in dismissal from the practice.

(Initial)_____ I understand that if I do not cancel a scheduled appointment at least 24 hours in advance I will be subject to a $25 cancellation fee.

Patient/Parent/Guardian Name (Print):___________________________________
Patient/Parent/Guardian Signature:______________________________________
Today's Date:_________________________

Medical Release, this is if you wish to have your medical history shared with your spouse, parent, grandparent, etc.

I, _______________________________, *(your name)* give authorization for my healthcare information to be released to the following individual:

Persons Name:_____________________________Relationship:_____________________________
Phone Number:_____________________________ Email:___________________________________
Signature:__________________________________ Date:___________________________________

1: Patient Information

Name: ____________________________________ Birth Date:__________________
Gender:_____________ SSN:________________________
Home Address:____
City:____________________________ State: _______________ Zip: ______________
Home Phone: _________________________Mobile Phone: _______________________
Work Phone:_____________________ Email: __________________________________
Please circle your preferred communication for reminders: email | phone | text
How did you hear about us? ____
Preferred Pharmacy (location):
____

2- Patient Portal

Would you like to have access to our patient portal? Yes | No

****If yes, please provide your email above so that we can send you the link.** You have 24 hours from today to activate the portal using the link we send you via email. To activate the portal, click on the link, enter the required information, and create a password. With access to the portal, you will be able to view your health records, patient education & information, lab work, and messages.

3- Emergency Contact Information

Emergency Contact: ____________________________ Relationship: ______________
Address (if different from above): ____
City:____________________________ State: _______________ Zip: ______________
Home Phone: _________________________Mobile Phone: _______________________
Work Phone:_____________________ Email: __________________________________

Emergency Contact: ____________________________ Relationship: ______________
Address (if different from above): ____
City:____________________________ State: _______________ Zip: ______________
Home Phone: _________________________Mobile Phone: _______________________
Work Phone:_____________________ Email: __________________________________

4- Insurance Information

Do you have insurance? Yes | No

****If you are not the policyholder of your insurance, please provide the following:**
Legal Name of Policyholder:___________________________ DOB:_______________
SSN:________________________ Relationship to Policyholder: __________________

Past Medical History?

____
____
____
____
____

Past Surgical History?

____
____
____
____
____

Family Medical History? (Medical problems that parents or siblings have)

_Mother:____
____
_Father:____
____
_Siblings:____

Alcohol use? (please circle) Never / Occasional / Frequent / Daily
Tobacco Use? (please circle) Never / Occasional / Frequent / Daily
Allergies to medicines? Y / N If yes, which medications?

____

Non medication allergies? Y/N If yes, please list with the severity

____

Any current medications:

Medication	Dosage	Frequency

REQUEST FOR MEDICAL RECORDS

PATIENT NAME:__________________________ **PATIENT DOB**:___________________

To ***(Physician/Office we are requesting from)***: ______________________________________

THEIR PHONE:____________________________ **FAX**:_____________________________

REQUESTING PHYSICIAN/ OFFICE: Mercy Wellness Clinic

MEDICAL RECORDS REQUESTED:

- ☐ History & Physical (within the last year)
- ☐ Lab Results (all)
- ☐ Radiology Report (all)
- ☐ Other:____

PATIENT/GUARDIAN SIGNATURE:____

Please send 10+ page records faxes to our EFax, in order to prevent clogging our paper fax.

Confidentiality Notice: The information contained in this facsimile may be confidential and legally privileged. It is intended **only** for use by the individual named. If you are not the intended recipient, you are hereby notified that the disclosure, copying, distribution, or taking of any action in regards to the contents of this fax – except its direct delivery to the intended recipient – is strictly prohibited. If you have received this fax in error, please notify the sender immediately and destroy this cover sheet along with its contents, and delete from your system, if applicable.

Aaron Terry, MD|Joel Dow, MD|Jamie Morris, FNP-C|Hannah Kalantari, FNP-C| Kelley Le Noir, FNP-C|Bradley Miller, PA-C|Jose Carcamo, FNP-C|Theresa Mund, FNP-C|
18568 Forty Six Parkway #1001, Spring Branch, Texas 78070|Ph: 830-438-9300**|E-Fax: 949-543-2196**, Paper Fax:210-455-0682|www.mercywellnessclinic.com