HIGHLAND AVENUE
PRIMARY CARE

Outpatient Information / Consent to Treat

PATIENT INFORMATION	Account #:	Medical Record #:	Date:
Patient name:		Referring doctor:	Referring doctor phone #:
Address:		Primary doctor:	
City/State/Zip:		Employer/School:	
(H) Phone #: Cell phone:	Work phone:	Email address:	
Date of birth:		Age: Marital status:	Sex:
Race:	Ethnicity:	Religion:	
Emergency contact (name):	Relationship:	(H) Phone #: (C)	
Responsible party:	Relationship:	DOB:	SS#:
Responsible party address:		City/State/Zip:	Phone #:

INSURANCE INFORMATION			
Primary Insurance:	Employer:	Secondary Insurance:	Employer:
Insurance ID #:	Insurance Group #:	Insurance ID #:	Insurance Group #:
Insured Name:		Insured Name:	
Address:		Address:	
City/State/Zip:		City/State/Zip:	
Insured DOB:	Insured Social Security #:	Insured DOB:	Insured Social Security #:

General Consent: I consent to medical care at Highland Avenue Primary Care. This includes needed lab work and HIV testing. By law, I understand that if there is an at-risk exposure to my blood or body fluids, I may be tested for HIV, Hepatitis B or C virus. Those test results will be shared with the healthcare worker who was exposed. I am aware that healthcare is not an exact science. No guarantees have been made. If I am hospitalized, I agree to send any valuables home. I agree that Highland Avenue Primary Care is not responsible for any loss or damage to my property.

I understand and agree with the above information. This consent is valid for three (3) years.

Patient or Responsible Person Signature: _____ ***Date*** _____ **Time** _____

Financial Responsibility: I agree to pay for all medical services provided. I understand that I may need to call my insurance company to see if they will approve and pay for the medical care. I am aware that the doctors and others providing care may not be employees of Highland Avenue Primary Care. They are acting on their own and not at the direction of Highland Avenue Primary Care. I understand I will receive a separate bill for their services. Please bill my health insurance plan as a service to me. I am aware that this does not mean that they will agree to pay for any services. I agree to pay whatever amount is not covered. Please apply for any health insurance coverage that may be available to me. I agree to help in this process. I assign all of my rights and claims for payment under any health insurance plan to Highland Avenue Primary Care and any other treating providers. I appoint Highland Avenue Primary Care, the other treating providers and/or their agents as my "authorized representative" to act for me in getting payment for services provided. If I pay more than what I owe for this medical visit, I agree that it can be used to pay for any unpaid bills I have with any Highland Avenue Primary Care facility. I give permission to be contacted for treatment or payment purposes via any of the telephone numbers or email addresses I have given. This includes contact with a pre-recorded message, automatic dialing system, artificial voice, email message, or text message. Contact may also be made by businesses helping my providers collect money that I owe.

I understand and agree with the above information. This consent is valid for three (3) years.

Patient or Responsible Person Signature: _____ ***Date*** _____ **Time** _____

*** For delivering mothers, all of these responsibilities apply to your newborn baby.**

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)