True Care
MEDICAL

10640 Business 21 | Hillsboro, MO 63050

Phone: (636) 797-2330 | Fax: (636) 797-8088 | team@truecarebettercare.com | www.truecarebettercare.com

Reset Fields

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: **DOB:**

Main Phone #: **SSN:**

Address:

FROM:

I request and authorize the release of healthcare records for the patient named above from the last 1 year:

asdfasdf

TO:

Dr. Sudhirkumar P. Shah, MD
True Care Medical Center
10640 Business 21
Hillsboro, MO 63050

I understand that I have a right to cancel this authorization at any time. I understand that if I wish to withdraw this authorization I must do so in writing. I must present my written cancellation to True Care Medical Center within a reasonable amount of time. I understand that the authorization withdrawal will not apply to information that has already been released due to this authorization. I understand that the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I do not have to sign this form to receive treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the responsibility for confidentiality rules. If I have questions about disclosures of my health information, I can contact my Physician's office management team.

Patient Signature: _____ Date: _____

If requesting release of information on behalf of a patient, specify your relationship & sign below:

_____

Relationship to Patient: *Signature:* *Date:*

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

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PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status:

Is this your legal name?	It not, what is your legal name?	Birth date:	Age:	Sex:

Address:

Social Security no.:	Home phone no.:	Cell phone no.:
E-Mail Address	**Occupation:**	**Employer:**

How did you hear about True Care Medical?
(Online, Word of mouth, Family, etc.)

☑ Referring Doctor Name:

☐ Other, Please Specify:

INSURANCE INFORMATION

Guarantor Information:	Birth date:	Address (if different):	Home phone no.:
Occupation:	**Employer:**	**Employer address:**	**Employer phone no.:**

Primary insurance Carrier:

Subscriber's name:	Subscriber's S.S. no.:	Subscriber Birth date:	Group no.:	Policy no.:	Co-payment:
					$

Patient's relationship to Guarantor:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize True Care Medical Center or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

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Personal History: (Check all that apply)

- ☐ Pneumonia
- ☐ Chronic Cough
- ☐ Jaundice
- ☐ Epilepsy/Seizures
- ☐ Rheumatism
- ☐ Ulcers
- ☐ Frequent Infections
- ☐ Colds/Strep Throat
- ☐ Bursitis
- ☐ Diabetes
- ☐ STD's
- ☐ Emotional Problems
- ☐ Migraines
- ☐ Allergies
- ☐ Rheumatic Fever
- ☐ Learning Disorder
- ☐ High/Low BP
- ☐ Kidney Disease
- ☐ Rectal Bleeding
- ☐ Arthritis
- ☐ Cancer
- ☐ Hives/Eczema
- ☐ Gout
- ☐ Thyroid
- ☐ Sciatica
- ☐ Gonorrhea
- ☐ Bladder Disorder
- ☐ Excessive Thirst
- ☐ Hay Fever
- ☐ Asthma
- ☐ Chest Pain
- ☐ Polio/Meningitis

Family History: (Has any blood relative had one of the following and who?)

- ☐ Cancer _____
- ☐ Tuberculosis _____
- ☐ Diabetes _____
- ☐ Heart Trouble _____
- ☐ High/Low BP _____
- ☐ Stroke _____
- ☐ Birth Defects _____
- ☐ Asthma _____

Surgeries: (Please list any past procedures you have had)

_____

_____

_____

Social History: (Please indicate how often and how many years)

Smoking: _____

Alcohol: _____

Other: _____

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MEDICATION LIST

Patient Name	Allergies

Date	Medication	Refills			
Start / Stop	Dosage/Direction/Amount	Date/Amount/Initials			

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ASSIGNMENT OF BENEFITS

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to True Care Medical Center any medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize True Care Medical Center to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of treatment or examination; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from True Care Medical Center and all affiliated Providers on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature: _____ Date: _____

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COMMUNICATIONS AUTHORIZATION

True Care Medical Center would like to communicate with you in the ways you prefer. By signing below, you allow us to disclose your Protected Health Information (PHI) as described on this form. PHI includes all information regarding your treatment and care. We may need to contact you for a number of reasons, including to provide information about your treatment or payment for your care. We may disclose your PHI in other ways if it is permitted by law and we determine such disclosure to be necessary under the circumstances.

Patient Name: _____

Date of Birth: _____ Today's Date: _____

I hereby request the following regarding the use and sharing of my PHI:

1. **Telephone Messages**: We may leave messages on answering machines or with individuals answering the phone at the numbers we have listed/written in this section, including referral information, prescription refill reminders, appointment reminders, test results or other information the Practice determines to be appropriate to leave on voice mail, or with the person answering the phone. Please write the number(s) you would like us to use on the line below or, if you do not want us to leave messages, write "None" below:

   _____

   _____

2. **Sharing PHI with family and friends**: In addition to any individuals who may be handling messages left as allowed in section 1 above, or individuals we may contact in emergencies or as otherwise allowed by law, you allow us to disclose PHI with the following family members, friends, or other individuals you list below and on any additional sheet attached to this form:

Printed Name / Relationship	Printed Name / Relationship
Street Address	Street Address
City, State, Zip	City, State, Zip
Phone number, including area code	Phone number, including area code

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COMMUNICATIONS AUTHORIZATION (cont.)

3. **Email Communications:** Sending your PHI by email carries risk. Most standard email does not provide a secure means of communication. There is a risk that PHI contained in an unencrypted email may be disclosed to, or accessed by, unauthorized individuals. Email can be lost or misdelivered. Use of more secure communications, such as by phone, are alternatives that are available to you or the secure patient portal.

4. **Sensitive Conditions:** We may discuss sensitive conditions directly with you, either in person, by mail, or over the phone. If you allow us to disclose PHI regarding certain sensitive conditions, including, but not limited to HIV/AIDS, substance abuse, mental health, genetic testing, sexually transmissible diseases and tuberculosis by patient portal, telephone messages or wireless calls as described on this form. **Please initial here**: _____

5. **Wireless Calls and Texting:** You consent to receive treatment and account-related calls from the Practice at the numbers you provided on the patient information form. Texts may be generated and sent using an automated notification system. Messaging may be prerecorded and delivered. You are not required to provide consent to receive calls or messages in order to receive healthcare services. Message and data rates may apply. **To stop text messages, simply reply STOP to the text message.**

Do not use emails or texting to communicate with us regarding urgent or time-sensitive matters. In a medical emergency, call 911.

It is your responsibility to make sure that only authorized people are allowed to access your email, phone messages and mobile devices. If individuals other than you receive your PHI sent in the ways allowed on this form, they may share it with others and state and federal privacy laws will not protect it.

You do not have to sign this form. If you do not sign, it will not affect the way we treat you. We will still communicate with you in person, by telephone, by mail or as otherwise allowed by law.

It is your responsibility to update this form and inform staff should any changes occur prior to the annual renewal.

_____ _____

Patient Name (Print) **Date**

_____

Patient/Legal Representative Signature

_____

Legal representative printed name and description of relationship (if applicable)

Print Save as