Hamilton Family Practice

Peter Coleman, M.D., PLLC
&
Hamilton Family Practice

Demographic and Consent for Treatment | 1 of 2

Date: _____ Referred by:_____

Personal Information:

Patient Name: _____ Sex (M/F): _____

LAST FIRST MI Date of Birth: _____

Social Security #: _____ Age: _____

Address: _____ Marital Status: _____

City: _____State_____Zip_____

Telephone: Best Number to Call:

Home: (_____)_____ ☐

Cell: (_____)_____ ☐

Other: (_____)_____ ☐

Email: _____

Billing Address (If different from above): _____

_____

Patient Employer _____ Occupation(s): _____

In School? _____Place of Education_____

Emergency Contact Information:

Person to contact in case of emergency: _____

Relationship to Patient: _____

Permission to release medical information: YES | NO Telephone Number: _(_____)_____

Insurance Information:

Primary Ins Carrier: _____ ID #: _____

Subscriber ID #: _____ Date of Birth: _____

Address: _____ Group #: _____

City: _____ State: _____ Zip: _____

Secondary Ins Carrier: _____ ID#:_____

Subscriber ID #: _____

Subscriber Employer: _____

Address: _____ Group #: _____

City: _____ State: _____ Zip: _____

I understand that payment is due when services are rendered. I understand that under conditions of my insurance policy, there may be a co-pay at the time of each office visit. I understand that I am financially responsible for any charges not paid by my insurance company. I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be directed to Peter Coleman M.D., PLLC for services rendered. I understand that if I do not have health insurance benefits, I will be responsible for full payment at the time of service.

_____

Signature of Patient or Personal Representative **Date**

Hamilton
Family
Practice

Demographic and Consent for Treatment | 2 of 2

I consent to the use or disclosure of my protected health information by Peter Coleman, M.D. PLLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Peter Coleman, M.D. PLLC. I understand that diagnosis or treatment of me by Peter Coleman, M.D. PLLC may be conditioned upon my consent as evidenced by my signature of this document.

I understand I have the right to request restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Peter Coleman, M.D. PLLC is not required to agree to the restrictions that I may request. However, if Peter Coleman, M.D. PLLC agrees to a restriction that I request, the restriction is binding on Peter Coleman, M.D. PLLC.

I have the right to revoke this consent, in writing, at any time, except to the extent that Peter Coleman, M.D. PLLC has taken action in reliance on this consent.

My protected health information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider(s), a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have a right to review Peter Coleman, M.D. PLLC's Notice of Privacy Practices prior to signing this document. Peter Coleman, M.D. PLLC's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices described the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Peter Coleman, M.D. PLLC.

The Notice of Privacy Practices for Peter Coleman, M.D. PLLC is also provided at 204 N. Hamilton Street Suite B Richmond, VA 23221. This notice of Privacy Practices also describes my rights and Peter Coleman, M.D. PLLC duties with respect to my protected health.

Peter Coleman, M.D. PLLC reserves the right to change the privacy practice that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

The information I provide to the doctor will be truthful and accurate and I will not withhold any information.

I consent to the use or disclosure of my protected health information by Peter Coleman, M.D. PLLC through e-mail or physical mail to the above named to aid in my on-going recovery and care. I understand that I can opt-out of this at any time by contacting Peter Coleman, M.D. PLLC.

I consent to the use of my e-mail and physical addresses for dissemination of information originated by Peter Coleman, M.D. PLLC. I understand that I can opt-out of this at any time by contacting Peter Coleman, M.D. PLLC.

_____

Signature of Patient or Personal Representative **Date**

_____

Name of Patient or Personal Representative **Date**

_____

Date

_____

Description