THE CLINIC AT FARMERS MEDSHOPPE
PO Box 669
Foxworth, MS 39483

Patient Information

Last Name _____ First Name _____ Middle Initial _____

Social Security Number _____ Date of Birth _____ Sex M ☐ F ☐

Mailing Address _____

City _____ State _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____

Email Address _____ *(please note this is very important information if we need to send you secure messages and information through our online portal, Follow My Health)*

Primary Physician _____ Referring Physician _____

Responsible Party

If patient is a minor, parent or legal guardian information:

Guarantor's Name _____ Relationship to Patient _____

Date of Birth _____Guarantor's Social Security Number _____

Guarantor's Billing Address _____

_____

Sex M ☐ F ☐ Guarantor's Phone Number ( ) _____

Emergency Contact *(please list the name of someone who does not live with you to contact in the event of an emergency)*

Name _____ Phone Number ( ) _____

Address _____

Insurance Information

Primary Insurance Name _____

Policy Number _____ Group Number _____ Effective Date _____

Name of Insured _____ Insured Phone Number ( ) _____

Insured Date of Birth _____ Insured Social Security Number _____

Address of Insured _____

Relationship to Patient _____ Insured Sex M ☐ F ☐

Secondary Insurance Name _____

Policy Number _____ Group Number _____ Effective Date _____

Name of Insured _____ Insured Phone Number ( ) _____

Insured Date of Birth _____ Insured Social Security Number _____

Address of Insured _____

Relationship to Patient _____ Insured Sex M ☐ F ☐

No insurance information to provide ☐

Cancellation Policy

We ask you notify our office if you are not able to keep your scheduled appointment, so that other patients can fill those time slots. Excessive no-shows, four in a twelve month period, may result in dismissal from our practice. We thank you in advance for taking time to cancel or reschedule those appointments you will not be able to keep. By signing below you agree to have read and understand this information.

Initial _____

Financial Policy

I am responsible for payment of services rendered to me by this clinic. (If the patient is under 18, the parent or legal guardian assumes responsibility for all charges.) Full payments are due at the time of service. I understand that if my account should ever require action by a collection agency or attorney in order to insure payment, the fees charged by these agents may be added to the balance due on the account. My signature below acknowledges understanding and agreement to the above referenced policy.

I hereby also authorize payment of medical benefits to the Clinic at Farmer's Medshoppe, LLC for all services provided to me. I authorize the physician to release any information acquired in the course of my treatment to process insurance claims, workers compensation claims, or any other agent that has been involved in my medical treatment. I also permit release of medical information to continue the process of care on my behalf. All other releases will require a release of information form to be completed.

Initial _____

Privacy Policy

Please sign below to acknowledge that you have read The Clinic at Farmer's Medshoppe's Notice of Privacy Practices. (This policy is posted next to the front desk check-in and you can request a copy of the policy for your convenience.)

Initial _____

_____ _____

Signature of Patient (Parent or Legal Guardian) **Date**

the **CLINIC**

Mike Johnson, CFNP

Authorization To Release Health Care Information

Please Print

Full Name (include middle initial) _____

Previous name if applicable _____

Date of Birth _____

DAY TIME PHONE: _____

I HEREBY REQUEST AND AUTHORIZE THE FOLLOWING RELEASE OF INFORMATION:

INFORMATION TO BE RELEASED BY:

ORGANIZATION: _____

ADDRESS: _____

_____

_____

(City, State, Zip) PHONE: _____

INFORMATION TO BE RELEASED TO:

Mike Johnson, CFNP
The Clinic
96 Hwy 587, Suite B
Foxworth, MS 39483
P.601-424-3540 F.601-424-3544

PURPOSE OF DISCLOSURE: ☐ Continuing Care ☐ Legal ☐ Insurance ☐ At Patient Request for Patient Use

Other (explain)_____

GENERAL MEDICAL INFORMATION:

	Dates: From/To		Dates: From/To
☐ Clinic Records	_____	☐ Home Care Records	_____
☐ Lab Results	_____	☐ Hospital Records	_____
☐ Radiology Reports	_____	☐ Skilled Nursing Facility Records	_____
☐ Radiology Films	_____	☐ Other	_____

_____ _____ _____

Date Signature of patient or patient's authorized representative Relationship to patient if not patient

RELEASE REQUIRING SPECIFIC CONSENT:

My initials and signature below authorize the release of health care information relating to testing, diagnosis or treatment for:

_____ HIV/AIDS _____ _____ Mental Health _____

_____ Sexually Transmitted Diseases _____ _____ Alcohol/Drug Abuse _____

_____ Reproductive Care (minors only)_____

MINORS—A minor patient's signature is required in order to release the following information (1) conditions relating to the minor's reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

_____ _____ _____

Date Signature of patient or patient's authorized representative Relationship to patient if not patient

☐ Check if patient is a minor

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits) except if I receive health care when the sole purpose of the health care is to create health information for a third party.

I understand that: a) I must revoke my authorization in writing and may do so by completing and signing the Revocation of Authorization form, DM-3523, available at my clinic's business or medical records office; b) If I revoke my authorization, it will not affect any actions already taken by The Clinic based upon this authorization; and c) I may not be able to revoke this authorization if the purpose of it was to obtain insurance.

Once The Clinic has disclosed health information, the recipient may re-disclose it in some situations. Privacy laws may no longer protect the information.

This authorization expires _____(date or event). Authorization will expire in ninety days if not otherwise specified.

WHO DO YOU WANT TO HAVE ACCESS TO YOUR MEDICAL INFORMATION?

The Clinic at Farmer's Medshoppe
PO Box 669
Foxworth, MS 39483

Patient Name _____

Date of Birth _____

I, _____ hereby authorize the following people to have access to my medical information, whether oral, written, or electronic. I understand this may include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse.

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

By signing this form, I hereby authorize you to discuss my medical condition, treamtment, and prognosis with anyone whose name appears above. I understand that if I give permission, I have the right to change my mind and revoke it. This must be in writing to the facility that maintais the individual's records that I authorized on this form. However, I understand that any revocation will be effective only to the extent that the facility has not already disclosed my PHI based on this authorization. I understand that if the persons or organizations I authorize to receive and/or use the protected health information described above are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

* If someone other than the patient (e.g. Power of Attorney) is requesting authorization, you must submit the appropriate legal documentation if it is not already on file with our office.

_____	_____
Signature of Patient, Parent, or legal Guardian	**Date**
_____	_____
Witness	**Date**