Coryell HEALTH

PATIENT CONSENT

Patient:_____ _____ _____ _____

LAST **FIRST** **MI** **MAIDEN**

Mailing Address:_____ City:_____ Zip:_____

Home Phone:_____ Alt. Phone:_____

DOB:_____ SSN:_____

Marital Status:_____ Driver's License:_____

Employer:_____ Emp. Phone:_____

Race: American IndianAsian/Pacific Islander Black Hispanic/Other White Other

Ethnicity: Hispanic Non-Hispanic **Gender:** Male Female

Emergency Contact Name:_____ Relationship:_____

Emergency Contact Phone:_____

PATIENT PORTAL ACCOUNT

A portal account will be created for you at your first visit. This is the primary method of communication with the office staff regarding results, and basic questions regarding your health.

Email:_____ Cell Phone Provider:_____

INSURANCE INFORMATION

Policyholder's Name:_____ Policyholder's SSN:_____

Policyholder's DOB:_____ Relationship to Patient:_____

Policy Number:_____ Name of Insurance:_____

CONSENT FOR TREATMENT: I, the undersigned, as the parent or on behalf of the patient, do hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of physician or mid-level practitioner at Coryell Medical Clinic (CMC). I agree to be seen by a non-physician provider and I have the right to be seen by a physician on request. I understand that no guarantee or assurance has been made as to the result within which may be obtained.

AUTHORIZATION OF RELEASE OF PHYSICIAN/MID-LEVEL PRACTITIONER RESPONSIBILITY: I authorize the release of any medical information to process insurance and request payment of insurance benefits for my medical treatment at CMC. I hereby release said clinic from all legal responsibility or liability that may arise from the release of such information.

I HAVE READ ALL OF THE ABOVE, OR HAD THE INFORMATION READ TO ME AND FULLY UNDERSTAND AND AGREE TO COMPLY AND CONSENT.

_____ _____ _____

PATIENT/RESPONSIBLE PARTY **DATE** **WITNESS**