El Camino Medical Clinic

1828 El Camino Real Suite 706. Burlingame, CA 94010

P: 650-777-9117 F: 650-860-3269

Date

Last Name First Name

Middle Initial SSN

Date of Birth Age Gender: ☐ Female ☐ Male

Street Address City, State, Zip

Home Phone # Work # Cell #

Marital Status : ☐ Single ☐ Married ☐ Divorced ☐ Widow

Spouse's Name Last First MI

Spouse's Phone Date of Birth SSN #

Emergency Contact Phone # Relationship

Insurance Information

Name of Insured Relationship to Patient

Address DOB SSN #

Name of Employer Work Phone #

Insurance Company Group # ID #

Ins. Co. Address Ins. Co. Phone #

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No If YES, PLEASE COMPLETE THE FOLLOWING

Name of Insured Relation to Patient

Address DOB SSN #

Name of Employer Work Phone

Insurance Company Group # ID #

Ins. Co. Address Ins. Co. Phone

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with name of Insurance Company _____ and assign directly to EL Camino Medical Clinic all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature of all insurance submissions.

Signature of Patient _____ Date _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent to El Camino Medical Clinic to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have the right to review the notice of Privacy Practices prior to signing this consent. El Camino Medical Clinic reserves the right to revise the Notice of Privacy Practices at any time.

With this consent, El Camino Medical Clinic may call my home or other alternative locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO. Such items may include appointment reminders, insurance items, billing questions and any call pertaining to my clinical care, including laboratory results among others. With this consent, El Camino Medical Clinic may mail to my home or other alternative location any item that assists the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are addressed to me personally. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to El Camino Medical Clinic, use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that are the practice has already made disclosure in reliance upon my prior consent.

Signature of Patient _____ Date _____

Print Form