Cannabis Card Ohio

Patient Demographic and Insurance Intake

Patient Name: ________________________________
Date of Birth: ________/_________/_________
SSN: ________-___________-___________
Gender *(please circle one)*: M F
Marital Status *(please circle one)*:
M S D W
Parent/Guardian Name:
____

Address: ________________________________
City: ____________State: ___ Zip: ______________
Home Phone: (____) ______-________
Cell Phone: (____) ______-________
E-mail: ___________________________
Emergency Contact: ____________________
Relationship: __________________________
Phone: (____) ______-________

I am the *(please circle one)*: patient | patient's guardian

By signing below, I understand that I am responsible for services that are considered non-covered expense by my insurer.

Signature: ____ Date: ____________________

Cannabis Card Ohio

Patient Consent and Authorization

Patient Name: ______________________________ Date of Birth: _______/_______/_______

HIPAA

I understand that, under the Health Insurance Portability and Accountability act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are required to agree to my requested restrictions, and if agreed, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing, except to this extent that you have taken action replying on this consent.

I am the *(please circle one)*:

patient | patient's guardian

Signature: ______________________________

Consent for Evaluation and/or Treatment

Date: ______________________________

By signing below, I am giving my consent to the practice of Family Urgent for evaluation and/or treatment. Once I have been examined, I understand that I will be informed of any medically recommended diagnostic procedures and/or treatments and given the option to accept or decline. **The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.**

I am the *(please circle one)*:

patient | patient's guardian

Signature: ______________________________

Date: ______________________________

Contact Information

Please list the person(s) with whom we can discuss your health information.

____

____

____