GROVE MEDICAL ASSOCIATES, P.C.

Please complete all sections prior to your visit. The signature of the patient, the custodial parent, or the legally responsible party is required.

Name of patient: _____ DOB: _____

Payment, Assignment, and Release

I understand that this office may bill my insurance carrier/government program as a courtesy to me but that I am financially responsible for all fees incurred and I agree to pay them in full. I assign all benefits payable to me by my insurance carrier/government program to Grove Medical Associates, P.C. I allow a photocopy of my signature to be used to process my insurance/government program claims for my lifetime. I understand that it is my responsibility to understand which treatment options are and are not covered by my health care policy and what I am required to do to secure those benefits.

If any attorney is involved in this medical injury, please sign below:

I hereby authorize the release of my medical records to any subpoenas that may be received by Grove Medical Associates, P.C. due to litigation.

Signature: _____ Date: _____

Pharmacy Information:

Name: _____ Location:_____ Phone:_____
Mail Order Name: _____ Fax # _____

Permission to leave Messages

By Signing Below, I authorize Grove Medical Associates, P.C. to leave non clinical messages in reference to any items that assist in carrying out my healthcare.

Home Phone: □ Yes □ No Work Phone: □ Yes □ No Cell Phone: □ Yes □ No
Preferred Phone: □ Home □ Cell □ Work
Preferred Time for Messages: □ Morning □ Afternoon □ Evening

Signature:_____ Date:_____

RX History Consent

By signing below, I agree to allow Grove Medical Associates, P.C. to review any prescription history available to my electronic health record.

Signature:_____ Date:_____

Grove Medical Associates, P.C.

Name of Patient:_____ DOB:_____

Please complete all sections below. This must be completed prior to your visit. The signature of the patient, the custodial parent, or the legally responsible party is required.

Privacy Practices (HIPAA)

By signing below, I acknowledge that I was provided with the Notice of Privacy Practices of Grove Medical Associates, Inc.

Signature:_____ Date:_____

Permission to Leave Messages

By signing below, I authorize Grove Medical Associates to leave non-clinical messages in reference to any items that assist in carrying out my healthcare.

Home Phone: □ Yes □ No Work Phone: □ Yes □ No Cell: □ Yes □ No

Preferred Phone: □ Home □ Work □ Cell

Preferred Time of Day for Messages: □ Morning □ Afternoon □ Evening

Signature:_____ Date:_____

Payment, Assignment and Release

I understand that this office may bill my insurance carrier/government program as a courtesy to me but that I am financially responsible for all fees incurred and I agree to pay them in full. I assign all benefits payable to me by my insurance carrier/government program to Grove Medical Associates. I allow a photocopy of my signature to be used to process my insurance/government program claims for my lifetime. I understand that it is my responsibility to understand which treatment options are and are not covered by my health care policy and what I am required to do to secure those benefits.

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RX History Consent

By signing below, I agree to allow Grove Medical Associates to review any prescription history available to my electronic health record.

Signature:_____ Date:_____

Pharmacy Information

Local Name: _____ Location: _____

Phone #_____

Mail Order Name:_____ Fax #_____