PATIENT CONSENT FORM

Patient Name:_____ **Date of Birth:** _____/ _____/_____

Address: _____ **City:**_____ **State:**_____ **Zip:**_____

Cell Phone: ( )_____-_____ **Home Phone:** ( )_____-_____ **Gender**:_____

Marital Status: _____ **Email:**_____

Social Security Number: _____-_____-_____

Employer Name & Phone: _____ **Work Phone:** ( )_____-_____

Preferred Language:_____ **Race:**_____

Ethnicity:☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Other ☐ Decline to answer

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Guarantor Name:_____ **Date of Birth:** _____/ _____/_____

Address: _____ **City:**_____ **State:**_____ **Zip:**_____

Cell Phone: ( )_____-_____ **Home Phone:** ( )_____-_____ **Race:**_____

Email:_____ **Social Security Number:** ____-____-____

Employer Name & Phone: _____ **Work Phone:** ( )_____-_____

Do you have Advanced Directives in place? **YES** or **NO** (If yes please circle one of the following)

Durable Power of Attorney Living Will Advanced Healthcare Directives

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Release of Information, Phone Message Consent, & Pharmacy of Choice

Your medical provider & other staff members will, at times, need to contact you. By filling out the information below, we will be better able to serve you.

Unless we have your permission to do so, **we will not**: leave detailed messages with anyone except the patient or legal guardian, leave information on an answering machine or leave detailed information on voicemails.

Please read below and *carefully* consider whom you *want* to have access to your medical information.

I, _____, give Satellite Med my permission to leave phone messages regarding my medical care & test results with the following individual(s) and/or answering systems. I fully understand that this consent will remain in effect until revoked in writing.

My cell phone/voicemail: ( )_____-_____ Initials:___

My home answering machine ( )_____-_____ Initials:___

My office/work voicemail ( )_____-_____ Initials:___

Please List a pharmacy of choice, if a medication is placed on hold for you

_____

Complete Back Section

My medical care &/or test results may be discussed with the following people:

Name:_____ Relationship:_____ Phone Number: ( )_____-_____ Initials:___

Name:_____ Relationship:_____ Phone Number: ( )_____-_____ Initials:___

Name:_____ Relationship:_____ Phone Number: ( )_____-_____ Initials:___

Name:_____ Relationship:_____ Phone Number: ( )_____-_____ Initials:___

I acknowledge by signing below I agree to Satellite Med's policies on credit, government insurances, privacy practices, photo identification, no show policy & accidental stick

Signature of Patient: _____ Date Signed: _____

Signature of Representative: _____ Date Signed: _____

Relationship to Patient: _____

Government Insurances Disclosure

Important question about Medicare or other Government Insurance. Please choose ONE of the options

☐ I have Medicare/TennCare and I still choose to be seen by a provider who has chosen to "Opt Out" of Medicare at this time. I also understand that if I choose to file to Medicare on my own, Satellite Med will not provide any letters for the purpose of filing to Medicare using form CMS1490S.

☐ I do not have Medicare/TennCare or other government insurances at this time and realize if I have applied for Medicare or other government insurances and any of them choose to accept me as a patient this visit will not be covered by Medicare or any other government insurance.