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Phone: (662) 205-4652
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ANNE HAIRE, D.O.
RYAN CLAIRE WIYGUL, CFNP
MALINDA INGRAM, CFNP

DATE: _____

NAME: _____ **SSN#** _____

DATE OF BIRTH: _____ **(M)** _____ **(F)** _____

STREET ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **CELL PHONE:** _____ **WORK PHONE:** _____

MARITAL STATUS ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Minor**

RACE ☐ **African-American** ☐ **Asian** ☐ **Hispanic** ☐ **White** ☐ **Other**

EMPLOYMENT STATUS ☐ **Full Time** ☐ **Not Employed** ☐ **Retired** ☐ **Student**

EMPLOYER NAME: _____

SPOUSE NAME (If applicable) _____

PARENT/GUARDIAN (IF PATIENT IS MINOR): _____ **BIRTHDATE:** _____

ADDRESS (IF DIFFERENT FROM PATIENT) _____

PARENT/RESPONSIBLE PERSON SOCIAL SECURITY # _____ **PHONE #** _____

EMERGENCY CONTACT: _____ **RELATION:** _____

PHONE NUMBER: **Home:** _____ Cell: _____

EMAIL ADDRESS: _____

PHARMACY NAME: _____ **PHARMACY LOCATION:** _____

INSURANCE POLICY HOLDER INFORMATION: **(if not in the patient's name)**

NAME: _____ **RELATION:** _____

ADDRESS: _____

PHONE: _____ **DOB:** _____ **SS#** _____

(OVER—Complete 2nd Page)

NAME_____ DATE OF BIRTH_____

Consent for Treatment

I desire to be seen and treated at Elite Medical ("Clinic") and hereby give my consent for the Clinic, its physicians and employees to see and treat me as they deem necessary and appropriate for diagnosis and treatment. I authorize and consent to examinations, blood tests, laboratory procedures, immunizations, medications, treatments and procedures rendered or performed at the Clinic or ordered or performed by its physicians or employees. I understand that I have the right to ask questions and to receive information regarding my care and treatment and the right to withdraw, in writing, my consent for treatment or tests. Initials: _____

Consent to monitor prescription history

I hereby give my consent to have my prescription history checked and understand that Elite Medical providers reserve the right to refuse prescription of certain medications without prior prescription history. Initials: _____

Patient Privacy Notice Acknowledgement

I do hereby acknowledge receipt (Privacy Notice Provided at your first visit) of Elite Medical's Patient Notice. Initials: _____

Financial Responsibility

I acknowledge and understand that **I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES** incurred during my visit including labs, xrays, medications and procedures whether or not they are reimbursed by my insurance company. Initials: _____

Payment Policy

I acknowledge understanding that applicable co-pays, co-insurance and deductibles are due at the time of service and any balances remaining on my account greater than 90 days plus associated collection fees will be sent to a collection agency of the clinic's choosing. Initials: _____

Assignment of Benefits

I hereby authorize Elite Medical to submit claims to my insurance company(ies) on my behalf, and my insurance company(ies) to make payments directly to Elite Medical for medical services. I also authorize Elite Medical to exchange medical information with my insurance company(ies) as needed for payment of services rendered. Initials: _____

Please list all those (family and/or friends) that we may talk to regarding your care and treatment.

Patient/Guardian Signature: _____ Date: _____

If not patient please document relationship to patient: _____