Easy Street Clinic
7202 E Carefree Drive
Carefree, AZ 85377-2872
480-595-0001

PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name:_____ Date of Birth:_____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Easy Street Clinic or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay, co-insurance, deductable amount and/or balance due that Easy Street Clinic is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Easy Street Clinic or physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION

I certify that I have received and read a copy of the Easy Street Clinic Patient Information Privacy Policy. I hereby authorize Easy Street Clinic or the physician individually to release ay of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZTION TO MAIL, CALL OR E-MAIL

I certify that I understand the privacy risks of mail, phone calls, and e-mail. I hereby authorize Easy Street Clinic representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Easy Street Clinic to that effect in writing.

CONSENT TO TREATMENT

I hereby consent to evaluation, testing, and treatment as directed by my Easy Street Clinic physician or his or her designee.

Patient Signature:_____ Date:_____

Guarantor Signature:_____ Date:_____
(If different from patient/or minor)

Guarantor Name: PLEASE PRINT_____