TUNICA COUNTY HEALTHCARE AUTHORITY

Patient Information Sheet

Acct#_____

Name:_____Race_____ Sex_____
Last First MI (optional)

Mailing Address: _____-_____

City: _____-____ State:_____ Zip:_____

SS#_____-____-_____ D.O.B____/____/____ Age:_____ Marital Status: S M D W (Circle One)

Home Phone (_____)-_____-_____ Cell (_____)-_____-_____Spouse's Name_____

Emergency Contact: _____ Phone (_____)-_____-_____

(We need the name and number of someone that DOES NOT *live with you.)*

Responsible Party: _____Address:_____

_____

(Self is the responsible party unless patient is a child.)

Employer Information:_____

Employer Phone: (_____)-_____-_____ Employer Address:_____

_____

Insurance Information (Primary)

Insurance Company_____ Policy ID_____

Group:_____ Member ID_____

Policy Holder's Name:_____D.O.B____/____/_____

Policy Holder's Social Security Number:_____-_____-_____ Relationship to Pt._____

Insurance Information (Secondary)

Insurance Company_____ Policy ID_____

Group:_____ Member ID_____

Policy Holder's Name:_____D.O.B____/____/_____

Policy Holder's Social Security Number:_____-_____-_____ Relationship to Pt._____

I understand that a fee is charged for all services at the time the services are rendered. I understand that I am ultimately responsible for full payments of the fee(s). I accept personal responsibility for payment of charges for services rendered to the above named. I accept responsibility for any legal fees and court cost incurred in the collection of this account. I hereby authorize the payment of medical insurance benefits directly to Tunica County Healthcare Authority. I understand that I am responsible for any unpaid balance. I authorize the release of any medical information necessary to process a claim with my insurance carrier or any third party payor. I authorize the release of records from Tunica County to any physicians, hospitals, other facilities or individuals involved in my treatment. I request that payment of authorized Medicare\Medicaid benefits be made to Tunica County Healthcare Authority for any services furnished to the above by that provider. I authorize any holder of medical information about the above to release to the Healthcare Financing Administration and its agency information needed to determine these benefits or the benefits payable for related services. I consent to examination and treatment rendered by members of the medical staff, their representatives, and/or associates, and clinic employees under the instruction of the physician or representative.

Understand and Agree: Signature_____ **Date:**_____

Please check and make sure all blanks are completed. Not acceptable unless completed entirely.

Medical and Surgical Consent
Release of Information and Payment Agreement

Tunica Medical Clinic
1813 U. S. Highway 61 North
Tunica, MS 38676

Tunica Resorts Medical Clinic
11273 U. S. Highway 61 North
Tunica Resorts, MS 38664

I. **MEDICAL AND SURGICAL CONSENT.** I, the undersigned (the patient or authorized representative) consent to the administration of necessary medical and surgical services related to the patient named below. This consent includes, but is not limited to, laboratory procedures, which may include the drawing/testing of blood, radiological procedures, medication administration, infusions, surgical procedures or treatment, transfusion of blood and blood products, and/or other services rendered to the patient by the physician, the nurse practitioner, and Clinic employees under the instruction of the physician.

I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me as to the results of treatments or examinations at this Clinic.

In addition, with respect to future visits or treatments at this Clinic, I consent to treatment in the future, which is of an ongoing and repetitive nature, for so long as such treatment is necessary or until this consent is withdrawn in writing by the undersigned or by another authorized representative* of the patient named below.

II. **RELEASE OF INFORMATION.** I hereby authorize this Clinic and any provider who has rendered services at this Clinic to release any and all information pertaining to the patient's medical treatment to enable the collection of benefits for the services rendered. This authorization includes, but is not limited to, release of information to Blue Cross/Blue Shield, Medicare, Medicaid, Cigna, United Healthcare, Workers' Compensation carriers, medical audit or billing companies, the Social Security Administration, or any insurance company or government agency which may be responsible, in whole or in part, for payment in exchange for the services rendered, whether or not such payment is in exchange for services rendered by Clinic's providers. Release of information is also authorized to any providers of follow-up medical care. Further I understand that the clinic and/or its providers may disclose all or any part of my medical record or medical information to any person or organization described or specifically named in the Clinic's Notice of Privacy Practices and to any other persons or organizations for any purpose described therein.

III. **FINANCIAL RESPONSIBILITY.** I understand and agree that I am financially responsible to this clinic and its providers. I understand that my insurance is accepted and filed as a courtesy and is no guarantee of coverage. In the event payments are made directly to this clinic and/or its providers, as authorized below, I understand that I am financially responsible for all charges not covered. **PLEASE NOTIFY US IF YOU HAVE RECEIVED A WORK-RELATED INJURY SO THAT WE CAN FILE UNDER YOUR WORKER'S COMPENSATION BENEFIT PROGRAM. YOUR MEDICAL INSURANCE WILL NOT COVER WORK-RELATED CLAIMS, AND YOU WILL BE HELD RESPONSIBLE FOR SUCH AMOUNTS IF NOT FILED APPROPRIATELY.**

IV. **ASSIGNMENT OF BENEFITS.** I hereby authorize the verification of medical benefits and payments directly to the treating physician/clinic.

V. **CERTIFICATION OF INFORMATION.** I certify that I have read or have been read the foregoing, am the patient or authorized representative* of the patient, and the forgoing conditions for treatment and release of information are fully understood and accepted. I certify that the information given by me in applying for payment under Title XVIII of XIX of the Social Security Act, or under other insurance coverage is correct.

VI. In order to assure the quality of our services a representative of Tunica County Clinics may contact you by telephone or in writing to ask your opinion of our services. We appreciate any comments you would like to share.

ACKNOWLEDGMENT OF PRIVACY NOTICE _____ **(initial or N/A if provided previously)**

UNABLE TO ACKNOWLEDGE BECAUSE: ☐ **unable to sign** ☐ **refused** ☐ **other:**_____

Patient's Name (Print): _____ **Date:**_____

Signature of Patient or Authorized Representative: _____
*** If patient is under the age of 18 years, authorized representative must be the parent and/or legal guardian.**

Witness' Name (Print):_____ **Date:**_____

Signature of Witness:_____