DEMOGRAPHIC INFORMATION SHEET

MEMORIAL MEDICAL GROUP, LLC

PATIENT INFORMATION

First Name: _____ MI: _____
Last Name: _____
Maiden Name: _____
Sex (Please Circle): M F Age: _____
Birth Date: (MM/DD/YYYY): _____
Marital Status: □ Single □ Married
□ Divorced □ Widowed
SSN#: _____
Race: □ White □ Black/African American
□ American Indian/Native Alaskan □ Asian
□ Hawaiian/Pacific Islander □ Two or more races
Preferred Language: _____
Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino
Is patient FULL TIME STUDENT? □ Yes □ No

ADDRESS

Street: _____
PO Box / Apt # : _____
City/State/Zip: _____
E-Mail: _____
Home #: _____
Work #: _____
Cell #: _____
Minors: Lives with □ Mother □ Father □ Both

MAILING ADDRESS (if different from above)

Street: _____
PO Box / Apt # : _____
City/State/Zip: _____

PATIENT or LEGAL GUARDIAN EMPLOYER

Employer Name: _____
Street: _____
PO Box / Suite # : _____
City/State/Zip: _____
Occupation: _____

(If applicable): PARENT / LEGAL GUARDIAN

First Name: _____ MI: _____
Last Name: _____
Relationship to Patient: _____
Home #: _____
Work #: _____
Cell #: _____

EMERGENCY CONTACT (OTHER THAN ABOVE)

First Name: _____ MI: _____
Last Name: _____
Relationship to Patient: _____
Home #: _____
Work #: _____
Cell #: _____

INSURANCE INFORMATION

(PLEASE PRESENT ALL CARDS SO THAT THEY MAY BE COPIED AND SAVED WITH YOUR RECORDS)

Primary Insurance Carrier

Insurance Carrier: _____
Insured Name: _____
Insured DOB (MM/DD/YYYY): _____
Insured SSN #: _____

Secondary Insurance Carrier

Insurance Carrier: _____
Insured Name: _____
Insured DOB (MM/DD/YYYY): _____
Insured SSN #: _____

Other Insurance Coverage

Is this visit for a Workers Compensation issue?
□ Yes □ No
Is this visit for an Auto Insurance issue?
□ Yes □ No

PHYSICIAN INFORMATION

Referring Physician: _____
Phone #: _____
Family Physician: _____
Phone #: _____

I hereby assign directly to Memorial Medical Group, LLC, or any of its subsidiaries, all medical benefits, if any, otherwise payable to me for services rendered. I understand that all services rendered to me (or my dependents) are charged directly to me and I am personally responsible for payment of all charges whether or not paid by insurance. The patient or their responsible legal guardian agrees to pay any and all costs of collection and/or attorney fees required to settle account balance. I authorize the release of all information necessary to my current or valid insurance carrier in order to secure the payment of benefits for services rendered .

_____
Patient Signature & Date

_____
Legal Guardians Signature & Date

_____
Relation to Patient

MEMORIAL MEDICAL GROUP

Patient Authorization for Discussion of Personal Health Information

Memorial Medical Group, LLC (MMG) is comprised of many providers from multiple specialties. MMG providers utilize one centralized computer system. In the event you are a current patient or become a patient of another MMG provider, the information you have included on this document will be followed in every MMG office that you are an active patient.

As a patient of MMG, from time to time we may need to contact you regarding your healthcare or to remind you of an upcoming appointment. To preserve your privacy, we would like you to indicate which methods of communication are acceptable for us to use when trying to contact you.

____ Home or Cell telephone

____ Text messaging

____ E-mail message

____ Work telephone

In the event we are unable to make direct contact with you, we will leave a message for you.

The HIPAA Privacy Rule generally requires us to protect the privacy of your health information. We are unable to discuss or share relevant information about you or your healthcare with others without your permission.

Because every patient and family is different, we cannot make assumptions on who may be involved in your care or payment for your care. Please provide us the names of family members or other individuals that you allow us to share information with concerning your health care or treatment received at any MMG provider practice.

Name (First, Last)	Relationship and Phone Number
Name (First, Last)	Relationship and Phone Number
Name (First, Last)	Relationship and Phone Number

We ask that you notify us and complete a new form whenever there are any changes you need to make to the information you have provided in this document.

PRINT Patient Name	Date of Birth
Patient or Legal Guardian Signature	Today's Date

MEMORIAL MEDICAL GROUP

Memorial Medical Group, LLC (MMG) is comprised of many providers from multiple specialties. MMG providers utilize one centralized computer system. In the event you are a current patient or become a patient of another MMG provider, the information you have included on this document will be followed in every MMG office that you are an active patient.

Consent to Retrieve Medication Prescription History

As a patient of MMG, I give consent to Memorial Medical Group, LLC to retrieve and use my medication history from SureScripts, an electronic prescriptions network. _____ (initial)

Accessing this information will ensure MMG has the most accurate information on your current prescription medication history, preferred pharmacy and prescription benefits.

Notice of Privacy Practices

Any health care professional, providers, staff and business associates of MMG authorized to enter information into your medical record or who may need access to your information must abide by Memorial's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how we may use or disclose your confidential information. As a patient of MMG, I acknowledge receipt of Memorial's Notice of Privacy Practices. _____ (initial)

Insurance Authorization and Assignment

I hereby assign directly to Memorial Medical Group, LLC, or any of its subsidiaries, all medical benefits, if any, otherwise payable to me for services rendered. I understand that all services rendered to me (or my dependents) are charged directly to me and I am personally responsible for payment of all charges whether or not paid by insurance. As the patient or the patient's responsible legal guardian, I agree to pay any and all costs of collection and/or attorney fees required to settle account balances. I authorize the release of all information necessary to my current or valid insurance carrier in order to secure the payment of benefits for the services rendered.

I agree to all of the above:

_____ _____

PRINT Patient Name Date of Birth

_____ _____

Patient Signature Today's Date

_____ _____

Legal Guardian Signature Relationship to Patient

MEMORIAL MEDICAL GROUP

Patient Portal Consent and Guidelines

Memorial Medical Group, LLC (MMG) is comprised of many providers from multiple specialties. MMG providers utilize one centralized computer system. In the event you are a current patient or become a patient of another MMG provider, the information you have included on this document will be followed in every MMG office that you are an active patient.

MMG offers secure viewing and communications as a service to patients who wish to view parts of their medical records and communicate with our provider practices. Some features of the MMG portal, such as online appointment scheduling and secure messaging may not be available initially. However, as MMG continues to develop our portal, these additional features may become available to our patients. MMG recognizes that secure messaging can be a valuable communication tool between our patients and the MMG provider practices, but it does have certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risk and agree to the conditions.

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from accessing confidential information they have no right to see. Secure information on the portal can only be read by someone who knows the correct password or pass-phrase to log in to the portal site.

Protecting Your Private Health Information and Risks:

Communication and viewing of information through the secure web portal prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain the electronic security of your information. However, keeping messages secure depends on you as well:

- MMG must have your correct personal e-mail address and;
- Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. It is imperative that MMG has your correct personal e-mail address and that you inform us of any changes to your personal e-mail address. You also need to keep track of who has access to your e-mail account so that only you, or someone you authorize, can see the messages you receive from MMG.

You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Online communications should never be used for emergencies or urgent matters.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent and guidelines regarding the MMG patient portal. I understand the risks associated with online communications and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth on the log in screen as well as any other instructions MMG or my physician may impose with regard to the patient portal and online communications. I understand and agree with the information that I have been provided and consent to MMG providing me with the access information to the online MMG Patient Portal utilizing the e-mail address I have provided below. I understand it is my responsibility to log on to the patient portal once I receive the access information from MMG.

PRINT Patient Name

Date of Birth

Patient Signature

Today's Date

Legal Guardian Signature

Relationship to Patient

Current personal E-mail address for MMG portal communications