**Lowry Medical Clinic**
**362 Park Creek Drive**
**Columbus, MS 39705**
**P: (662)-244-8864**
**F: 888-491-5452**
**Slater B. Lowry, M.D.**

## Patient Information

Date: _____/_____/_____

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

Address: _____
Street city state Zip

Best Contact Number:(_____) _____ Alternative number: (_____)_____

Email: _____ Social Security Number: _____

Sex: M or F Marital Status: □ Single □ Married □ Divorced □Widowed

If married, spouse's name: _____

Employer: _____ Work Phone: (____) _____

Do you have a Living Will? □ Yes □ No Do you have a Power of Attorney? □Yes □No

Emergency Contact:_____ Relationship:_____

Phone Number: (_____) _____

## Insurance Information

| Primary Insurance | Secondary Insurance |
|---|---|
| Subscriber: _____ | Subscriber: _____ |
| Subscriber's DOB: _____ | Subscriber's DOB: _____ |
| Subscriber's Social: _____ | Subscriber's Social: _____ |
| Policy Number: _____ | Policy Number: _____ |
| Group Number: _____ | Group Number: _____ |

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## Physician and Medication Information

Primary concern and need for patient appointment with Dr. Lowry: _____

_____

Physicians you currently see and reason why: _____

_____

Medication List/Dosage: Current medical issues:

_____

_____

_____

_____

_____

Please list any past surgeries and past medical history:

_____

_____

_____

By signing this, I am consenting to LMC to use and disclose any information to carry out treatment, payment and health care operations.

Printed Name: _____

Signature_____ Date_____

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## Authorization, Release and Agreement to Pay for Services Rendered

As a patient, I authorize the healthcare providers at Lowry Medical Clinic to perform procedures and treatments as may be necessary for proper medical care.

**Medicare**: I hereby request that payment of authorized Medicare benefits to or on my behalf for services furnished in or by Lowry Medical Clinic shall be made to the clinic and I specifically assign such benefits to the clinic. I hereby certify that all information given by me in connection with applying for benefits under Title XVIII of the Social Security Act is true, correct and complete in all respects. I understand that payment for certain services not deemed medically necessary are not authorized under the Medicare/Medicaid Program and that I shall be responsible for such charges unless other third-party coverage is available.

**Insurance**: I hereby assign Lowry medical Clinic all rights, benefits and interest under any insurance policy, health plan, or third-party payer liable to me, in consideration for services rendered by the provider. I hereby authorize payment to Lowry Medical Clinic by any insurance policy, health plan, or third-party payer for treatment received. Secondary third-party payer insurance claims will not be automatically filed by Lowry Medical Clinic.

**Financial responsibility**: I understand that I am financially responsible to Lowry Medical Clinic for all charges not covered or paid by insurance. I also understand and agree that all deductibles, coinsurance, non-covered charges, and other items not paid by insurance, health plan or other third-party payers are due and payable at time of service. I understand, following a collection of insurance payment after filing on my behalf, I will receive a statement from Lowry medical Clinic for either the remainder of amount on my deductible or non-covered services, and that payment is expected. I understand that Lowry Medical Clinic reserves the right to seek the services of a reputable collection agency if statements go unanswered. I agree that in the case of default of payment and, if my account is placed in the care of a collection agency or attorney for collection, or suit, all collections fees, finance charges, attorney fees, costs and other expenses will be paid by me.

**Consent for Release of Health Information for Billing and Payment:** I consent to the release of my health information (medical records, medical results, and any and all other health information) by Lowry Medical Clinic or any physician or provider invo0lved in my care for the purpose of billing, claims management, medical data processing, reimbursement, certification to any insurance company, third party payer, health plan or government agency necessary for the billing and payment of my account.

Patient Name: _____ Date:_____

Patient Signature: _____

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## Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for LOWRY MEDICAL CLINIC to use and disclose protected health information about me to carry out treatment, payment, and health care operations. (The Notice of Privacy Practices provided by LMC describes such uses and disclosures more completely and is continually located in the waiting room at LMC.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. LMC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Lowry Medical Clinic.

With this consent, LMC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TREATMENT, PAYMENT, and HEALTH CARE OPERATIONS, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, LMC may mail to my home or other alternate location any items that assist the practice in carrying out TREATMENT, PAYMENT, and HEALTH CARE OPERATION, such as appointment reminder cards, and patient statements.

With this consent, LMC may email to my home or other alternate location any items that assist the practice in carrying out TREATMENT, PAYMENT, and HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements. I have the right to request that LMC restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT, and HEALTH CARE OPERATIONS. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow LMC to use and disclose my PHI to carry out treatment, payment and health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, LOWRY MEDICAL CLINIC may decline to provide treatment to me.

Signed by: _____ Date: _____

Printed Name: _____

I agree that my medical information may be disclosed to the following:

1._____ 2. _____

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# NO SHOW POLICY

We regret patients must sometimes wait a lengthy time to be seen by a physician. Due to the high demand of appointments and to be respectful of the medical needs of all of our patients please be courteous and call our office promptly if you are unable to attend an appointment.

We require a 24 notice to cancel scheduled appointments.

**There will be a $25.00 charge for every appointment missed without proper notification.**

If 2 appointments are missed without proper notification, we reserve the right to dismiss the patient from care.

Please sign below acknowledging your understanding of this policy.

Signed by: _____ Date: _____