First Name:_____ Last Name:_____

Date of Birth:_____ Sex: Male / Female (circle one)

Physical Street Address:_____

Physical Street Address 2:_____

City:_____ State:_____ Zip Code:_____

County: Calhoun / Gilmer / Other:_____

Home Phone:_____ Mobile Phone:_____

Follow up requested? Yes / No Patient Insurance / State Billing

This specimen was provided voluntarily for analysis and I authorize AIT Laboratories, a HealthTrackRx company, to process, bill, and provide results. I agree to the declaration and terms in the patient acknowledgement, irrevocable assignment of benefits, and consent for treatment and insurance billing on the back of this form.

Signature:_____ Date:_____

Minnie Hamilton Health System

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: The hospital and attending physician are authorized to furnish any medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment of my care, or to any physician and/or medical facility to which I may be transferred.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to Minnie Hamilton Health System of hospital benefits payable to me including major medical insurance. I also authorize payment of surgical or medical, including Major Medical Insurance benefits to attending physician, but not to exceed regular charges for these services. I understand that I am financially responsible to the hospital and physicians for the charges not covered by this assignment. I further agree that in the event hospital benefits exceed the charges of Minnie Hamilton Health System for its services in connection with this hospitalization, any such excess amount may first be applied to any other indebtedness due by me or my immediate family to the hospital on account of other admissions, and the balance, if any remains, paid to me.

MEDICARE PATIENTS CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release to the Medicare Bureau, or its intermediaries, or carriers, any information about me needed for processing my claim for Medicare benefits. This authorization will expire two years from the date shown below, however, I reserve the right to withdraw this authorization at any time.

MEDICAID PAYMENTS CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under XIX of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.

STATEMENT TO PERMIT PAYMENT OF HOSPITAL AND/OR MEDICAL INSURANCE BENEFITS TO HOSPITAL PHYSICIANS: I hereby assign payment for the unpaid charges for certain inpatient physicians' services furnished by specialists or by physicians for whom the hospital is authorized to bill. I understand that I am financially responsible to the hospital and physicians for any health insurance deductible and coinsurance.

ACKNOWLEDGEMENT OF PRIVACY RECEIPT: I acknowledge that I have received a copy of the Minnie Hamilton Health System *NOTICE OF PRIVACY PRACTICES.*

ESCRIBE CONSENT: External Prescription History: With my consent, Minnie Hamilton Health System and its providers have the ability to view my external prescription history via SureScripts for purpose of my care and treatment. I understand that my medication history from multiple other medical providers, insurance companies, and pharmacy benefit managers may be viewable and that granting this permission will allow my providers to better coordinate my care and to maximize the effectiveness and safety of my treatment plan.

PORTAL CONSENT: I understand that when I provide my email address or designate an alternate email address for a delegate of my choosing, this will allow access to my electronic protected health information through the secure patient portal.