# *PERRY KALIS M.D., INC.*
## PATIENT INFORMATION SHEET

**Legal Name :** _____
(Last) (First) (Middle or Maiden)

**Address:** _____ **Home Phone:** _____

**City, St Zip** _____ **Work/Cell Phone:** _____

**Social Security #** _____ **Your Employer Name:** _____
**(If self-employed, please list name of business.)**

**Date of Birth** _____ **Your Employer Address:** _____

**Sex (Circle) Female / Male** **Your Occupation:** _____

**Marital Status : M S D W** **Spouse Name:** _____

**If Student (Circle) PT / FT** **Spouse Employer:**_____

**Who to contact in case of Emergency? _____**

**Relationship to patient: _____ Phone#: _____**

**Alternative contact person not living with you _____Phone #_____**

**Pharmacy of choice: _____If mail in Pharm do you need 3 month supply Yes __ No __**

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## Insurance Information

| | **List Name of Insurance** | **Insured Name** |
|---|---|---|
| ***Primary :*** | _____ | _____ |
| ***Secondary:*** | _____ | _____ |
| ***Tertiary:*** | _____ | _____ |

**Responsible Party for Minor Child** _____
**Address:** _____
_____
**Phone:** _____

**** * * * Workers Compensation visits, please advise the receptionist immediately. * * * ****

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I authorize Dr Kalis and his staff to release information regarding my care (test results, appointments, a patient account balances) only to the following people. Please check then sign on the BACK.

____ **ONLY to Myself** _____ **Other, Please list name** _____

____ **to my spouse** **Relationship** _____

**____ It is ok to leave information on my answering machine at home**

**____ It is ok to Email result letters.** **Email address** _____**@** _____

# Consent Form

I consent to the use or disclosure of my protected health information by Perry Kalis M.D. Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Perry Kalis M.D. Inc. I understand that diagnosis or treatment of me by Perry Kalis M.D. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Perry Kalis M.D., Inc. is not required to agree to the restrictions that I may request. However, if Perry Kalis M.D., Inc. agrees to a restriction that I request, the restriction is binding on Perry Kalis M.D., Inc. and Perry Kalis M.D.

I have the right to revoke this consent, in writing, at any time, except to the extent that Perry Kalis M.D. or Perry Kalis M.D., Inc. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Perry Kalis M.D., Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I authorize payment from Medicare and/or Insurance benefits be made on my behalf to Perry Kalis M.D., Inc. for all services furnished to me by that group.

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered.

I hereby give my consent for treatment by Perry Kalis M.D. and his staff. I hereby authorized treatment of the above minor child, and will be fully responsible for any charges incurred.

_____ _____

Signature of Patient , Parent, or Responsible Party Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority