Patient

Information

Packet

Our goal is to meet your equipment and supply needs so that you can maintain the lifestyle you desire.

Insurance Intake Form

Please complete all of the following as accurately as possible:

Name _____

Birthdate _____/_____/_____ Age _____Sex _____ SS#: _____/_____/_____

Address _____

City _____ Zip _____

Phone (H) _____ _____ (W) _____ _____

Married _____ Separated _____ Divorced _____ Widow _____ Single _____ Other _____

Weight: _____ Height: _____

Primary Insured: _____

Policy #: _____ Group #: _____

Secondary Insured: _____

Policy #: _____Group #: _____

Subscriber Insurance Information: _____

Subscriber's Name: _____

Date of Birth: _____/_____/_____ SS#: _____/_____/_____
(ONLY IF YOU HAVE TRICARE)

Subscriber's Relationship to Patient: _____

Policy #: _____ Group #: _____

How did you hear about us? _____

_____ _____
Patient Signature Date

Mercy Home Medical Supply, Inc.
3801-E Sycamore Dairy Road,
Fayetteville, NC 28303 910.779.2334

Photo Identification Consent

I consent for a photograph to be made of my ID and Insurance card (or person for whom I am a legal guardian). I understand that the information will only be used for identification purposes and will be stored securely in my medical record. Refusal to photograph will not affect my medical care. If I prefer not have my information photographed, I will be asked to provide identification and Insurance card at each visit.

If I have any questions or wish to withdraw my consent in the future, I may contact: 910.779.2334

Please check all that are applicable:

☐ I am an adult granting permission to Mercy Home Medical Supply, Inc.

Print your name here:

_____

☐ I am the guardian granting permission for Mercy Home Medical Supply, Inc.

Print guardian name here:

_____

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated today for my medical equipment/supplies. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my information is for medical insurance purpose. ☐
3. I agree to a photo consent of my identification and Insurace card to Mercy Home Medical Supply, Inc. ☐
4. I understand that my medical notes and data collected during this visit for medical equipment/supplies, may be looked at by individuals from Mercy Home Medical Supply, Inc. I give permission for these individuals to have access to my records. ☐

Signature: _____Date_____

_____ _____

Print Name Date

_____ _____ _____

Name of Person Date Signature taking consent.

HIPAA Medical Authorization Form
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____
Patient Address: _____
Patient Date of Birth: _____
Patient Social Security #: _____
Patient Phone Number: _____
Date(s) of Treatment: _____

Medical Facilities Authorized to Release Information:

MERCY HOME MEDICAL SUPPLY, INC.

FAYETTEVILLE, NC 28303

910-779-2334

Authorized recipient of Information: _____

Expiration of this authorization: _____

Information to be released and disclosed:

All information of any kind on file concerning me including, but not limited to, Medical Bills, Patient Billing Records, Pictures/Photos, Clinic Notes, Summary Health Information (all dictated reports), History and Physical, Discharge Summary, Operative Report, Entire Record, Laboratory Reports, Radiology Reports, Emergency Department Reports, Physical Therapy/Occupational Therapy Notes, Patient Discharge Instructions, X-ray Films, Electronic Medical Records, Consultations, Emergency Room Record, EDG/ECG Tests, Therapy Notes, Progress Notes, Medication Records, Doctor's Orders, Nurse's Notes, Treatment Plans, Commitment Papers, Pathology Reports, MAR, Urgent Care Center Notes, etc.

Purpose or Need for release or disclosure: _____.

I understand I may refuse to sign this authorization, and that my refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or my eligibility for health benefits. I acknowledge that the information disclosed pursuant to this information may be subject to re-disclosure by the recipient and no longer will be protected by Federal Law. I understand I have the right to revoke this authorization by written notice to the healthcare providers listed on this authorization. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, sexually transmitted disease, and acquired immunodeficiency syndrome and human immunodeficiency virus. I understand and agree that there may be costs associated with this request in compliance with State or Federal copying laws.

_____ _____

Patient Signature Date