



Patient ID: _____

Patient Contact Information:

Patient Name: _____ DOB: _____

Home Phone: _____ Cell Phone: _____

Street Address: _____

Mailing Address: _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed ___ Domestic Partner

Email Address: _____

Employer Information

Employer Name: _____ Phone Number: _____

Employer Address: _____

Emergency contact information

Emergency Contact Name: _____ Phone Number: _____

I consent to be contacted by MD Medical Group regarding any marketing solicitations including but not limited to preventive visits, new services, offers and/or promotions.

I hereby give my consent to be contacted via the following method(s):

- Text Messages Email Mail Voice Recorded Messages
- Telephone Calls Promotional Materials

I also understand that I may revoke my consent in writing at any time.

Consent to Treat

I hereby authorize employees and agents of Top Care Medical, PA / MD Medical Group (including physicians, physician assistants, and nurse practitioners and other employees and staff members) to render medical evaluations and care to the patient indicated below. I understand that a physician assistant/nurse practitioner is not a doctor. I also understand that a physician assistant/nurse practitioner is a graduate of a certified training program and is licensed by the State board. Under the supervision of a physician, a physician assistant/nurse practitioner can diagnose, treat and monitor acute and chronic diseases, as well as provide health maintenance care. Supervision does not require the physical presence of a supervising physician. I understand that at any time I can refuse to see the physician assistant/nurse practitioner and request to see a physician.

Complete this Section ONLY if the patient is a minor

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient.



Preferred Pharmacy Info

Name: _____

Address: _____ Phone: _____

Rx History Consent Form

Medication History Transactions provides the health care provider with information about your current and past prescriptions. This allows the personnel to be better informed about potential medication issues and use the information to improve safety and quality. Medication history data can indicate: Compliance with prescribed regimens, therapeutic interventions, drug-drug and drug-allergy interaction, adverse drug reactions and duplicate therapy.

The medication history information would include medications prescribed by your healthcare provider at Top Care Medical Group, Inc. (MDMG) as well as other healthcare providers involved in your care and third- party pharmacy for treatment purposes. It may include sensitive information, including but not limited to, medications related to mental health conditions, venereal diseases/sexual transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic disease and HIV/AIDS.

Financial Responsibility

I hereby authorize and assign payment of medical benefits directly to Topcare Medical, PA (MD Medical Group - hereinafter "MDMG"). I authorize medical information needed to determine these benefits or the benefits payable for the related services be released to the insurance company and its agents. I understand that even though I have some type of insurance coverage, I am responsible for the payment and it is due upon request. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expense of MDMG, if any, including but not limited to, a collection fee of up to 25% of the debt should my account be assigned to a collection agency for collections. I have been instructed where to review MDMG's Patient Financial Policies and Rights and Responsibilities.

Acknowledgement of Receipt of MD Medical Group (MDMG) Notice of Privacy Practices

The Health Insurance Portability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act are federal government regulations designed to ensure privacy and security of patient's protected health information (PHI) and to ensure that you are aware of your rights and how your medical information can be used in providing and arranging your medical care.

MDMG is furnishing you with its Notice of Privacy Practices, which are available in hard copy or at the company's website (www.mdmedicalgroup.us), which provides information about how MDMG and its providers may use and/or disclose protected health information about you for treatment, payment, healthcare operations, and as otherwise allowed by law.

Communication of PHI

I hereby authorize **MD Medical Group** to leave detailed, personal health information by the following means: (Please complete all that apply)

- Voicemail message at my:
 - home work cell number: _____
 - Verbal message with my spouse or partner: (area code and number) _____
- _____ (name of spouse or partner) _____ (area code and number)
- _____ (name of other person/relationship) _____ (area code and number)

Patient Portal

- Yes, I want to communicate my information with me through a secure system that is designed to keep my information safe. You will be notified via email when there is secure information for review.
- No, I do not want to use electronic communication as a way to communicate my information to me.

By signing this form, I acknowledge that I have received MDMG's consent to treat, financial responsibility, privacy practices notification, and communication preferences. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing below that I am responsible for payment of services in full before services are rendered.

Patient Name

Signature of Patient, Parent, or Legal Guardian

Date