Highpoint Health Center

317 Cleveland Avenue, Suit 101A

Highland Park, NJ 08904

732 249 9800

PATIENT CONSENT

CONSENT FOR TREATMENT:
I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedure. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the Instructions of such physician(s).

RELEASE OF INFORMATION:

By signing this form, you are granting consent to Highpoint Health Center to use and disclose your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose the protected health information. You have a legal right to review our Notice of Privacy Practices before you sign the consent, and we encourage you to read it in full.

Our Notice of Privacy Practice is subject to change. If we can change our notice, you may obtain a copy of the revised notice by telephoning our office at (732)-249-9800. You have the right to request us to restricts how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required to by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to evoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on our consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:
I certify that the information given by me is applying for payment under Title XVII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration of its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

VERIFICATION OF NON-PREGNANCY (Female Patient Only):
By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, not is pregnancy suspect or confirmed at this particular time.
Date of last menstrual period:_____

_____ _____
Print Patient's Name

_____ _____
Patient's Signature

_____ _____
Patient/ Guardian (If under the age of 18)

Highpoint Health Solutions

317 Cleveland Ave Suite 101A
Highland Park, NJ 08904
732-249-9800

Date: _____

PERSONAL HISTORY

Date of Birth: _____ Social Security#: _____

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

CONTACT INFORMATION

Home Phone: _____ Cell Phone: _____

Email Address: _____

Current Medications/Vitamins (Please include dosage and frequency):

_____

_____

_____

Medical/Surgical History:

_____

_____

_____