

William O. Dickey M.D., John P. Molina, Au.D. & Michael R. Iliff, Au.D. Patient Profile Consent

Legal Name (First MI Last)		Patient SS#		Patient Date of Birth	
Address		Sex:	Email Address		Marital Status
City, State, Zip		Phone #1/Type of Number		Phone #2/Type of Number	
Employer		Occupation		Please tell us how your heard about our practice	
Policy Holder Name		Policy Holder SS#		Policy Holder Date of Birth	
Referring Physician		Primary Care Physician		Pharmacy	

Insurance Information

<input type="checkbox"/> Card Attached	Primary Insurance	Secondary Insurance
Insurance Name/Subscriber Name		
Subscriber Relationship to Patient		
Subscriber Employer/Ins Policy# and Group#		
Office Visit Copay		

Consent for Treatment: I, the undersigned, voluntarily agree to the tests, procedures, and/or treatments which the physician has deemed necessary and which are administered to or performed on me under the direction of the physician or his/her designee.

Consent for Treatment of Minors: I, the undersigned, understand that a minor child (17 and under) must have my consent to be treated. I understand that I must be present at each appointment for any child aged 14 and under. If the child is between the ages of 15 and 17, I understand that I must send a note with the child to the appointment consenting for the child to be treated. The notes must contain the date, a statement of consent, and my signature. Further, I understand that consent for treatment does not alter the legal requirements for confidentiality. I also understand that Colorado Law provides for minors to seek care without parental consent for certain issues.

Consent to Communicate Medical Results: I, the undersigned, understand that medical results will be communicated directly to me unless I specifically identify individuals to whom information may be communicated (see box below to authorize other family members to receive results). Please indicate how we may inform you of test results (check all that apply):

	Use info above	Okay to leave voice mail?	Ok to leave message with another person (see below)
<input type="checkbox"/> Call my work number	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Call my cell phone:	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Call my home number	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Mail to my home address	<input type="checkbox"/>	<input type="checkbox"/> Mail to a different address (at right):	

In the event that I am not available to receive medical results when called upon, I authorize William O. Dickey M.D. P. C., John P. Molina Au.D., or Michael R. Iliff, Au.D. to leave medical information with any of the names identified below. It is my responsibility to notify these persons that such information may be left with them and I agree not to hold William O. Dickey M.D., John P. Molina, Au.D., or Michael R. Iliff, Au.D. responsible for information not conveyed to me through these persons. (Please indicate below which family members are authorized to receive result information.)

Family Information (Please list all other members of your household even if not authorized to receive results.)

Name (First MI Last)	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth	Relation	*OK to Release Results? No <input type="checkbox"/> Yes <input type="checkbox"/>
Name (First MI Last)	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth	Relation	*OK to Release Results? No <input type="checkbox"/> Yes <input type="checkbox"/>

Emergency Contact information

Name of relative or friend to contact in case of an emergency		
Name	Relation	Phone

Please read and initial each of the items below

Initials

_____ I certify to the accuracy of the above information and understand that I am personally responsible for the full amount of my charges regardless of insurance coverage. I authorize the release of any medical or other information necessary to process claims.

_____ I further authorize payment of medical benefits directly to the undersigned physician.

_____ I also herby acknowledge that I received William O. Dickey M.D., John P. Molina, Au.D., & Michael R. Iliff, Au.D.'s Notice of Privacy Practices.

_____ I understand that if I am unable to make my appointment, that I need to call and reschedule 24 hours prior to my appointment. I also understand if I arrive late for my appointment, I may be asked to reschedule, or be worked into the day. If I do not show for my appointment and do not call the office to cancel my appointment in advance, I will be considered a no show and will be charged a \$25 no show fee.

_____ I also understand if my check is returned for non-sufficient funds, I will be responsible for paying a \$25.00 fee in addition to re-issuing payment for the returned check.

Name (please Print) Signature Relationship to patient Date