MAJOR MEDICAL CLINIC
FAMILY MEDICINE
STEVEN D. MAJOR, M.D.

Steven D. Major, M.D., PLLC
6882 Elmore Road, Southaven, MS 38671, 662-349-6200, Fax: 662-349-6962

NEW PATIENT INFORMATION

Last name _____ First _____ M.I. _____ Address _____

City, State, Zip _____ Phone # (____)-_____ Social Security # _____

Emergency Name and Number _____ Patient's Date of Birth _____

Age____ Gender M___F___ Marital Status: M___S___D___W___ Race _____

Email address _____ Cell # (____) _____

Employer _____ Address _____ Phone# _____

Pharmacy Name _____ Phone# _____

INSURANCE INFORMATION *(Please complete all blanks.)*

Primary Insurance:

Name _____ Address _____ Phone # _____

City, State, Zip _____ ID # _____ Group # _____

Policy Holder's Name (if other than patient) _____ Relation to patient _____

Policy Holder's Date of Birth _____ Is pre-certification and/or referral authorization required? _____

Policy Holder's SS# _____

Secondary Insurance:

Name _____ Address _____ Phone # _____

City, State, Zip _____ ID # _____ Group # _____

Policy Holder's Name (if other than patient) _____ Relation to patient _____

Policy Holder's Date of Birth _____ Is pre-certification and/or referral authorization required? _____

Policy Holder's SS# _____

Do you have a living will on file or would you like assistance in completing one? _____Yes _____No

I authorize release of any medical information necessary to process this claim. I also authorize Medicare and/or other insurance payment of medical benefits to Steven D. Major, MD for services provided to me. I understand that I am financially responsible to Steven D. Major, MD for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverage's are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees.

I also agree to give Medical Insurance Filing Services, Inc. authorization to file insurance for medical claims on behalf of Steven D. Major, MD.

Patient's Signature _____ Date _____

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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name:_____ Address: _____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____

Social Security Number: _____

1. I authorize, (Clinic or Physicians name): _____

   Address: _____ City: _____

   State: _____ Zip Code: _____ Phone number: _____ Fax number: _____

   to disclose the information from my record to:

   Steven D. Major, M.D.
   6882 Elmore Rd. • Southaven, MS 38671
   Phone (662) 349-6200 Fax (662) 349-6962

2. The purpose(s) for which the information is being disclosed is/are: _____

   _____

3. I authorize the disclosure of the following information from my medical record:

   _____Complete medical record _____ Laboratory results _____ Progress notes

   Other: _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

   Patients signature: _____ Date: _____

5. I understand that I have a right to revoke this authorization at any time by presenting my written revocation to the office of **Steven D. Major, M.D., 6882 Elmore Rd., Southaven, MS 38671.** I understand that the revocation will not apply to information that has already been used or disclosed under this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If this authorization has not been revoked, it will terminate on the following date, event or condition: _____

   If I fail to specify an expiration date, event or condition, this authorization will automatically expire in six months.

   Patients signature: _____ Date: _____

6. I understand that I can refuse to sign this authorization. I need not sign this form to obtain treatment, payment, or health plan enrollment or eligibility. I understand that my disclosure of information carries with it the potential for redisclosure by the recipient and that the information may then no longer be protected by federal confidentiality rules. If I have questions about users or disclosures of my health information, I can contact the privacy office at 6882 Elmore Rd., Southaven, MS 38671.

   Signature of Patient or Representative: _____ Date: _____

   Printed Name of Patient or Representative: _____ Date: _____

   If Personal Representative, the patient is unable to sign because: _____

   _____

_____

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CONSENT FOR TREATMENT AND CARE

I, the undersigned, do hereby agree and give my consent for Dr. Steven Major to furnish medical care and treatment to myself or _____ which is considered necessary and appropriate in diagnosing or treating my/their physical condition. I also state that I have a LIVING WILL on file or will inquire to staff on how to obtain one.

STATEMENT OF FINANCIAL RESPONSIBILITY

All services rendered are the responsibility of the patient. As a courtesy to our patients, we will file with your insurance carrier. The patient is responsible for all fees, regardless of insurance coverage or the usual and customary fees provided by your insurance company. Payment is expected at time of treatment unless prior arrangements have been made with our office. I understand that I will be responsible for any costs incurred as a result of my account being turned over to a collection agency or attorney. I understand that I will be responsible for a service charge for any returned checks.

INSURANCE AUTHORIZATION AND BENEFITS ASSIGNMENT

I hereby authorize Dr. Steven Major to release all information necessary, including medical records, requested by insurance companies with whom I have coverage and any public agency or its agents to secure payment for myself or my dependents. I hereby authorize payment of benefits to be made directly to Dr. Steven Major for services provided to me or my dependents.

MEDICARE ONE-TIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Steven Major for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable for related services.

MEDIGAP AUTHORIZATION

I request that payment of authorized Medigap benefits be made on my behalf to Dr. Steven Major for any services furnished me by that provider. I authorize any holder of medical information about me to release any information needed to determine those benefits or the benefits payable for related services to my Medigap carrier.

CREDIT INVESTIGATION CONSENT

I also agree to give Medical Insurance Filing Services, Inc. authorization necessary to file insurance for medical claims on behalf of Dr. Steven Major.

Patient's Signature _____ Date _____

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This is to notify all patients of Major Medical Clinic that if you are prescribed any type of narcotic/controlled substance from the clinic you are subject to random drug tests whether it be by buccal swab or a urine sample. This is in compliance with all the new DEA requirements and Prescription Monitoring Program Reporting. By signing this you are stating you understand this policy and you have the right to revoke this agreement in writing at any time.

By signing this form I am acknowledging that Major Medical Clinic has the right to refuse to refill my prescriptions and may terminate me from the practice if I exhibit unruly behavior, inappropriate conversations with staff regarding clinic policies and if I display unruly behavior or threaten Major Medical Clinic staff members.

_____ _____

Patient Signature Date

_____ _____

Patient Name(Please Print) Witness