JEFFERSON CITY MEDICAL GROUP, P.C.
JEFFERSON CITY, MISSOURI

CONSENT TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS, CONSENT FOR TREATMENT AND FINANCIAL OBLIGATION

Patient Name:	Date of Birth:	Chart #:	Effective Date:

1. **Consent for Treatment:** I, the undersigned, a patient of Jefferson City Medical Group, P.C. ("JCMG"), request and authorize my attending physician, his or her nurse practitioner and/or nurse assistant, and any other JCMG physician or JCMG healthcare provider who he or she may designate as his or her associates or assistants or who he or she may refer me to, to administer such treatment as is medically necessary (hereinafter referred to singularly and collectively as "JCMG Healthcare Provider(s)"). I understand that JCMG is a multispecialty group and that I may see more than JCMG Healthcare Provider(s) for my medical care. Therefore, I voluntarily consent to said evaluation, medical care and treatment by the JCMG Healthcare Provider(s). This consent further applies to any and all such medical services, care, diagnostic procedures and/or medical treatments as my JCMG Healthcare Provider(s) deem reasonable and necessary, including, but not limited to testing, laboratory pathology and radiology. All of the foregoing referenced health care and services shall be referred to generally throughout the rest of this document as ("My Health Care"). In the event that invasive procedures are deemed medically necessary, I further understand that additional consent will be obtained by the appropriate JCMG Healthcare Provider(s).

2. **Release of Information:** I hereby authorize any JCMG Healthcare Provider(s) and/or JCMG, to release, transfer, provider access to, divulge, and furnish my private healthcare information and medical records, including, but not limited to, diagnosis, medical history, treatment history and/or plan, test and diagnostic results, prescriptions, and all billing, payment and collection information and records as follows:

    1. to JCMG employees, JCMG Healthcare Provider(s) and non-JCMG healthcare providers to provide, coordinate, and/or manage My Health Care and related services; and

    2. to my health insurance company, health insurance maintenance organization, health care network, health care plan, Medicare, Medicaid, Medigap, Health Care Financing Administration/Center for Medicare/Medicaid, third party administrator of any such health care plans or companies, or authorized agent of any such health care plans or companies which provide insurance coverage in whole or in part for My Health Care (hereinafter separately or collectively referred to as "Plan(s)") in order to obtain insurance payments, determine eligibility or coverage, coordinate benefits, adjudicate or subrogate health benefit claims, provide risk adjustment of amounts due, provide billing and collection services, manage claims, obtain payment under a contract for reinsurance, process data for related healthcare, review medical necessity or coverage, and provide utilization review; and

    3. to JCMG's employees, agents or subcontractors to engage in billing and account collection activities in an effort to obtain payment from me and/or from and applicable Plan(s) for My Health Care.

3. **Payment:** I hereby authorize and direct any of the Plan(s) listed above to make payment directly to JCMG on my behalf whenever possible.

4. **Discrimination:** If you feel you have been denied services because of your race, color, national origin, age, sex, disability, religious or political beliefs; you may file a complaint of discrimination with the clinic administrator of JCMG or Administration Department of Social Services or the Department of Health and Human Services. If you need assistance please ask for Administration.

5. **Contracted Plan(s):** If my Plan(s) is a contracted plan, i.e. HMO, PPO, or Open Access product, I understand and agree that I am financially responsible for non-covered medical services, co-payments, co-insurance, and deductibles as set forth in the provisions of my Plan(s).

6. **Assignment of Benefits:** In consideration for services provided, I hereby assign JCMG, the benefits due to me covering My Health Care costs and expenses otherwise payable to me, for the Plan(s), policy or policies I have in effect for Plan(s) coverage, insurance coverage and policy(s) named, whichever applicable.

7. **Financial Obligation for JCMG:** I understand and agree that I am financially responsible for the payment of all charges, that are my responsibility, for My Health Care, unless waived by contractual agreements between JCMG and my Plan(s) or insurer or if prohibited by state, federal laws or regulations. JCMG cannot accept responsibility for collecting your insurance or Plan(s) claim if there is no contractual agreement between JCMG and the Plan(s) or insurer.

8. **Collection Fees, Costs and Venue:** In the event that it becomes necessary for JCMG to employ the services of a collection agency or an attorney to pursue collection of my account, I agree to be responsible for the payment of such collection fees. Interest on my outstanding account shall accrue at the rate of 1.5% per month. Should JCMG file a legal action to collect on my account, I hereby waive venue and agree that venue shall be appropriate in Cole County, Missouri.

9. **Force and Effect:** I have read and understand the above provisions and agree to all terms and conditions as stated. A copy of this consent shall be as effective and valid as the original. This consent and all provisions contained herein shall be in force without expiration or time limitation no matter whether I change my insurance coverage or Plans(s). I understand and agree that none of the provisions of this Consent in anyway seek to limit applicable Federal, State, and Local law, including, but not limited to the Health Insurance Portability and Accounting Act of 1996 ("HIPAA").

10. **Telephone Consent:** I give JCMG (including its agents and third party collection agents) permission to contact me by telephone at the telephone number or numbers I provided during the registration process, or at any time in the future, including wireless telephone numbers or other telephone numbers that may result in charges to me. JCMG and its agents may leave messages for me at these numbers and may send text messages or email communications using the email address or addresses I provided. These voice messages and emails and text communications may include information required by law (including debt collection laws) related to amounts, I owe JCMG as well as messages related to my continued care and treatment.

    I also understand that JCMG and its agents, including debt collection agencies, may use pre-recorded/artificial voice messages and/or use an automatic dialing devise (an autodialer) to deliver messages related to my account and amounts, I may owe JCMG. I also authorize JCMG and its agents to use the number or numbers provided for such pre-recorded or auto dialer messages. If I want to limit these communications to a specific number or numbers, I understand that I must request that only a designated number or numbers may be used for these purposes.

11. **No Show Fee:** I may be billed a $25.00 fee for any no-show or same day cancellation.

Date:

Signature:	Guardian (If Applicable):

12. Witness:

PATIENT REGISTRATION

Jefferson City Medical Group

Please Print *(Legal)*

Patient Name: (First) (Middle) (Last) (Nickname)

Physical Address:

City, State, Zip:

Billing Address:

City, State, Zip:

Home Phone: - -

Cell Phone: - -

Emergency Contact Person:

Relationship:

Emergency Phone: - -

Age:

Date of Birth: / /

Sex: ☐ M ☐ F

Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Other

Social Security Number: - -

Ethnicity: ☐ Non Hispanic ☐ Hispanic ☐ Unknown ☐ Decline

Patient Race: ☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian ☐ Other ☐ Unknown ☐ Decline

Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ French ☐ German ☐ Finnish ☐ Czech ☐ Italian ☐ Other

Email Address:

Pharmacy:

Patient's Employer:

Occupation:

Address:

Work Phone: - - Ext:

Referring Physician:

Primary Physician:

Spouse:

Social Security Number: - -

Birth Date: / /

Spouse's Employer:

Phone: - -

Address:

Nearest Relative:
(Not living with you)

Relationship:

Phone: - -

Person Responsible for Payment

(only complete if different than patient)

Name:

Address:

Home Phone Number: - -

How Related:

Employer:

Work Phone Number: - -

Occupation:

Social Security Number: - -

Insurance Information

Must present Insurance card.

Insurance Company Name:

Policy Number:

Group Number:

Subscriber Name:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Social Security Number: - -

Birth Date: / /

Secondary Insurance Company: (If applicable)

Policy Number:

Group Number:

Subscriber Name:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Social Security Number: - -

Birth Date: / /

SIGNATURE OF PATIENT OR LEGAL GUARDIAN IF PATIENT IS A MINOR:

✓

Date: / /

JCMG
JEFFERSON CITY MEDICAL GROUP
with Signature Care

Chart Number: _____

2023-2024 Annual Seasonal
INFLUENZA VACCINE CONSENT FORM

Please review the Vaccine Information Sheet and answer the following:

1. Do you have a severe allergy to eggs? Yes No

2. Have you ever had a serious adverse reaction to the flu vaccine or any other vaccination? Yes No

3. Do you currently have an acute respiratory infection or fever or are you recovering from a moderate-severe illness? Yes No

4. Do you have a history of Guillain-Barre Syndrome (GBS)? Yes No

5. Women: Are you pregnant? Yes No

6. Children 6 months through 8 years of age: N/A
   How many flu seasons has this child been vaccinated? _____
   If only one, how many flu vaccines did they receive that season? _____

I have read or have had explained to me the risks and benefits of influenza and the influenza vaccine. I have reviewed the vaccine information sheet and have had the opportunity to ask questions which were answered to my satisfaction. I understand, as with all medical treatment, that there is no guarantee that I will become immune; that the vaccine will prevent me from developing influenza and that I will not experience any adverse side effect(s) from the vaccine. I believe that I understand the benefits and the risks of this vaccine and authorize the nurse associated with JCMG to administer the vaccination to me at this time.

Please Print:

Name: _____ _____ _____
Last Name First Name Middle Initial

Date of Birth: _____ Age: _____ Phone #: _____

Address: _____

Signature: _____

VACCINE INFORMATION			
Product:		**Lot Number:**	**Expiration Date:**
GSK FluLaval Quad PFS (6 months-and older) 0.5ml PFS			
SANOFI- ___ Flublok PF Quadrivalent Egg Free (18-64 yrs.) 0.5ml PFS ___ Fluzone HD (Age 65+) 0.5ml PFS			
Date Administered:	**Site of injection**: ( ) Right ( ) Left ( ) Deltoid ( ) Thigh	**Injection given by:**	