Insurance Information

Reason for Being Seen Today: _____

Primary Insurance

Insurance Company: _____ Group#: _____ ID#: _____

Policy Holder Name: _____ Relationship to Patient: _____

Social Security #: _____ - _____ - _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Ext: _____ ☐ Same as mine ☐ Same as Responsible Party

Insured Employed by: _____ Business Address: _____

City: _____ State: _____ Zip: _____ Business Phone #: _____

Secondary Insurance

Insurance Company: _____ Group#: _____ ID#: _____

Policy Holder Name: _____ Relationship to Patient: _____

Social Security #: _____ - _____ - _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Ext: _____ ☐ Same as mine ☐ Same as Responsible Party

Insured Employed by: _____ Business Address: _____

City: _____ State: _____ Zip: _____ Business Phone #: _____

Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (Protected Health Information or PHI) and medical information by Classen Urgent Care Clinic / Classen Family Medicine in order to carry out treatment, payment or health care operations. You should review our Notice of Privacy Practices for a more complete description of the potential release and use of such information. You have the right to review such Notice prior to signing this Consent Form – it is available from our front desk staff.
We reserve the right to change the terms of the Notice of Privacy Practices at any time. If we do make changes to the terms of the Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.
You retain the right to request that we further restrict how your PHI is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

Authorization to release information to a family member/friend.

As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to nominate one or more persons to act on your behalf with respect to your PHI. By completing this form, you are informing us of your wish to designate the named person as your personal representative with respect to uses and disclosures of your PHI.

I, _____(printed name and date of birth), hereby nominate the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of my PHI.

_____(*Printed Name of Personal Representative)*
The authority of this person, when acting as my personal representative, is restricted to the following functions:
This person is to be afforded all of the privileges that would be afforded to me with respect to my Protected Health Information.
I acknowledge and understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to Classen Urgent Care Clinic and/or Classen Family Medicine 2824 Classen Blvd., Norman, OK 73071. I further acknowledge and understand that any revocation does not apply to the extent that persons authorized to use or disclose my Protected Health Information have already acted in reliance on this designation.

By signing below, I consent to be treated at CUCC and/or CFM. I attest that the information given is accurate to the best of my knowledge. I have been given access to a copy of the Notice of Privacy Practices, Financial Responsibilities and Ownership Disclosure. I understand and agree to the terms.

Signature of Patient/Guardian: _____ **Date:** _____