



Summa Physicians Inc
Kase, Speelman & Cullen M.D.'s
970 E Washington Street, Suite 4-B, Medina, OH 44256

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

Address:

City: State: Zip:

Patient Sex: M/F Birthdate: Marital Status: Social Security #:

Home Phone # () Cell Phone # () Preferred Number: Home/Cell

Email Address:

Referring Physician Name: Phone #: ()

Family Physician Name: Phone #: ()

Employer: Phone #: ()

Spouse's Name (if Applicable): Spouse's Birthday:

Spouse's SS#: Spouse's Employer:

This office has my permission to speak with about my Health Information.

Relationship: Phone #: ()

PRIMARY INSURANCE

Insurance Name: Policy #:

Address: Group #:

City, State, Zip: Effective Date:

Policyholder Name: Policyholder DOB:

Policyholder SS#: Relationship to patient:

SECONDARY INSURANCE

Insurance Name: Policy #:

Address: Group #:

City, State, Zip: Effective Date:

Policyholder Name: Policyholder DOB:

Policyholder SS#: Relationship to patient:

I hereby permit Summa Physicians, Inc to release any information acquired in the course of my examination or treatment required to process this claim. I also authorize treatment by the physicians, staff and radiology personnel of Summa Physicians Inc. I hereby agree to pay any Copays, Deductibles, and amounts over UCR, and/or excluded charges, exceeding payments from insurances with whom Summa Physicians, Inc does not accept assignment with, and/or all Copays and Deductibles with those they do. I hereby request my insurance carrier to pay on my behalf insurance benefits to Summa Physicians, Inc for services rendered. I understand this authorization will be effective until revoked in writing. Summa Physicians, Inc's fees are not established by insurance companies, I am responsible for my account.

Signed: Date:



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Privacy Consent – For the Use and Disclosure of Protected Health Information

I hereby give my consent to Summa Physicians Inc to use and disclose my health information for the purposes of treatment, payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize this Summa Physicians Inc, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for whom I am the legal guardian. This medical care may include any service related to prevention, condition or sick care, including assessment of medical concerns, supportive care, palliative care, VNA support care needs and services related to my general medical conditions. This may include (but not limited to) evaluation of medical problems, medical management, minor procedures, diagnostic testing, therapeutic care, counseling, the prescribing of drugs, or other services required by your care. This consent includes contact and discussion with other health care professionals, such as my primary care or specialists for your care and treatment.

Consent for release of Information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operations needs as identified in the practice privacy notice. My medical record may include information about any and all conditions I have identified to this practice including genetic issues, drug or substance abuse, and HIV or AIDS, or other related diagnosis and conditions.

Consent related to the Privacy Notice: I have had a chance to review this Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If this practice agrees to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at anytime, but the Practice may refuse further services at that time. If I revoke this consent, the revocation does not take affect until the practice receives it.

Patient's Name: _____

Patient/Guardian: _____ Date: _____

Name Printed: _____ If not patient, relationship: _____

Copy of Practice Privacy Statement signed or initiated with patient/guardian on: _____

Patient unable to sign privacy statement due to: _____

Revocation:

I hereby revoke the consent given above:

Patient/Guardian: _____ Date: _____

Name Printed: _____ If not patient, relationship: _____