

EASTERN SHORE RURAL HEALTH SYSTEM, INC. PATIENT REGISTRATION / CONSENT

| PATIENT INFORMATION | | Print changes on each line and initial last line of this section |
|---|---|--|
| Patient Name | | |
| Social Security Number | | |
| Date of Birth | | |
| Sex | | |
| Street Address | | |
| Mailing Address | | |
| Home Phone | | |
| Work Phone | | |
| Leave a Message | | |
| PCP | | |
| Guarantor (Responsible Party) | | |
| Initial if correct -----> | | |
| OTHER PATIENT / FINANCIAL INFORMATION | | Check one item on each line |
| Race | <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Refused to Report | |
| Ethnicity | <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Refused to Report | |
| Farmworker Status | <input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal <input type="checkbox"/> None | |
| Veteran | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Household Income (annual) | <input type="checkbox"/> Exceeds \$50,000 <input type="checkbox"/> Exceeds \$35,000 <input type="checkbox"/> Exceeds \$25,000 <input type="checkbox"/> Exceeds \$15,000 <input type="checkbox"/> Exceeds \$10,000 | |
| Number of household members supported by this income: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9+ | | |
| INSURANCE INFORMATION | | Print changes on each line and initial last line of this section |
| Primary Insurance | | |
| Subscriber ID | | |
| Copay | | |
| Secondary Insurance | | |
| Subscriber ID | | |
| Copay | | |
| Initial if correct -----> | | |
| EMPLOYER INFORMATION | | Print changes on each line and initial last line of this section |
| Employer Name | | |
| Patient Work Phone | | |
| Employer Address | | |
| Initial if correct -----> | | |
| ADDITIONAL INFORMATION | | Print changes on each line and initial last line of this section |
| Emergency Contact Name: | | |
| Emergency Contact Phone: | | |
| Default Pharmacy Name: | | |
| Default Pharmacy Number: | | |
| Initial if correct -----> | | |

| PATIENT INFORMATION | |
|---------------------|--|
| Patient Name | |

Authorization and Release:

- A. I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me (or my minor child or ward herein named) during the period of such care to third party payers (including insurance companies). I authorize and request third party payers (including insurance companies) to pay directly to the doctor or doctor's group benefits otherwise payable to me. I understand that my third party payers (including insurance companies) may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to me (or my minor child or ward herein named). I accept full responsibility for any legal or collection agency fees, not to exceed 40% should my account become delinquent.
- B. I authorize Eastern Shore Rural Health System, Inc. (ESRHS) through its appropriate personnel and/or medical staff to perform, administer, prescribe or have performed, administered or prescribed upon: to me or for me (or my minor child or ward herein named) such examinations, tests, immunizations, injections and diagnostic procedures as are deemed necessary. I also certify that all information contained herein is true and correct to the best of my knowledge and believe that no facts have been omitted.
- C. I am aware that section 32.1-45 of the Virginia Code provides that whenever any Physician or any person employed by (or under the direction and control of) Hospital or Physicians is directly exposed to Patient's body fluid in a manner that may, according to the then current guideline of the Center for Disease Control, transmit human immunodeficiency virus (the AIDS virus), Patient will be deemed to have consented to testing for infection with the AIDS virus without his or her actual consent. The results of this test may be released to the person who was exposed to Patient's body fluids, also without Patient's actual consent.
- D. For dental services only: I authorize ESRHS to render routine dental care, such as examinations, restorations (fillings), root canals, stainless steel crowns, cleanings, space maintenance, and extractions. If applicable, I authorize ESRHS to use pediatric dental care techniques such as voice control, timeout, and passive restraints per ESRHS policy (available upon request) for dental care of my minor child or ward herein named. Please initial _____

Protected Health Information Patient Consent:

Eastern Shore Rural Health System, Inc. (ESRHS) provides this section to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). ESRHS will protect PHI in accordance with HIPAA regulations.

- E. I understand the ESRHS Notice of Privacy Practices (NPP) provides information about how ESRHS may use and disclose protected health information (PHI) about me (or my minor child or ward herein named). I have had the opportunity to review this notice. The NPP contains a Patients Rights section describing patient rights under the law. ESRHS reserves the right to change the NPP. If ESRHS changes the notice, I may obtain a revised copy by contacting ESRHS.
- F. I have the right to request that ESRHS restricts how PHI about me (or my minor child or ward herein named) is used or disclosed for treatment, payment, and health care operations. ESRHS is not required to agree to this restriction, but if ESRHS does, ESRHS shall honor that agreement.
- G. I consent to ESRHS' use and disclosure of PHI about me (or my minor child or ward herein named) for treatment, payment, and health care operations. Examples of health care operations include, but are not limited to, prescriptions, laboratory, x-ray, referrals, and consults with other health care providers. I have the right to revoke this consent, in writing; however, such a revocation shall not affect any disclosure ESRHS has already made in prior consent. Such a revocation will negatively affect the timeliness of care.
- H. I authorize ESRHS to request and receive any and all records held by the Virginia Department of Health Professions relating to Schedule II-V controlled substances dispensed to me (or to my minor child or ward herein named).
- I. I authorize ESRHS to disclose and receive confidential health information to or from RxHub National Patient Health Information Network and/or pharmacies as required to provide prescription services to me (or my minor child or ward herein named).
- J. I have received the Notice of Privacy Practices from ESRHS and consent to treatment upon execution of this consent.
- K. If applicable: I authorize the release of all PHI about me (or my minor child or ward herein named) to the following individual(s) as well as allow them to participate in patient care activities (i.e. transport to and from appointment, assist in examinations, etc.) and consent to treatment as deemed necessary (examinations, tests, immunizations, injections and diagnostic procedures):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Patient or Parent/Guardian of Minor

Date