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 / Cell Phone		
Work Phone		
Leave a Message		
PCP		
Guarantor (Responsible Party)		
	Initial if correct ---------->	

☐ Sign me up for the patient portal!

Enter your email address below:

_____

OTHER PATIENT / FINANCIAL INFORMATION					Check one item on each line
Race	American Indian or Alaskan Native		Asian		Native Hawaiian
	Black or African American		White		Other Pacific Islander
	Refused to Report				More than one race
Ethnicity	Hispanic	Non-Hispanic		Refused to Report	
Farmworker Status	Migrant	Seasonal		None	
Veteran	Yes	No			
Household Income (annual)	Exceeds $50,000	Exceeds $35,000		Exceeds $25,000	
	Exceeds $15,000	Exceeds $10,000		Less than $10,000	
Number of household members supported by this income:	1	2	3	4	5	6	7	8	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 have the right to decline treatment. 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: 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 stabilization per ESRHS policy (available upon request) for dental care of my minor child or ward herein named. This authorization includes routine dental care as described above in all ESRHS settings with or without my physical presence.
Please initial _____

E. I understand that ESRHS has a 'No Show' policy (available upon request) and I am responsible for appropriately maintaining my appointments. I understand that ESRHS has a list of patient rights and responsibilities available upon request. I understand my rights and agree to my responsibilities as a patient. 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.

F. 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.

G. 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.

H. 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.

I. I authorize ESRHS to request and receive any records held by the Virginia Department of Health Professions or other appropriate state program relating to Schedule II-V controlled substances dispensed to me (or to my minor child or ward herein named).

J. 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).

K. I have received the Notice of Privacy Practices from ESRHS and consent to treatment upon execution of this consent.

L. 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). I am responsible for notifying ESRHS if I wish to revoke these privileges. Privileges are only applicable for one year from signature date.

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

_____ _____ _____
Signature of Patient or Parent/Guardian of Minor **Printed Name** **Date**

Authorization for Release of Information

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: _____ _____ _____ SS#: _____ _____ _____
MO DAY YR

ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

RECEIVING PROVIDER NAME/ORGANIZATION: Eastern Shore Rural Health System, Inc.

ADDRESS: 20280 Market Street CITY: Onancock STATE: VA ZIP: 23417

PHONE: (757) 414-0400 FAX: (757) 414-0569

SPECIFIC INFORMATION TO BE RELEASED:

I hereby authorize this provider to release specific information from my medical record to the receiving organization below:

	DATES:	
❑ Pap Smear Report	Most Recent_____	Provider/Location_____
❑ Colonoscopy/Operative Report	Most Recent_____	Provider/Location_____
❑ Hemoglobin A1c Results	Most Recent_____	Provider/Location_____
❑ Mammogram	Most Recent_____	Provider/Location_____
❑ PT/INR Results	Most Recent_____	Provider/Location_____
❑ Labs	Most Recent_____	Provider/Location_____
❑ Progress Notes	Most Recent_____	Provider/Location_____
❑ Immunization Record	Most Recent_____	Provider/Location_____
❑ Other	Most Recent_____	Provider/Location_____

PURPOSE OF DISCLOSURE:
❑ Other (please specify): _Continuity of care / Primary Care Physician / Medical Home_____

The authorization granted by the patient, in signing this document, will expire in one calendar year from the date on this form.

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____ _____ _____
RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT