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

PATIENT INFORMATION			INSURANCE INFORMATION	
Patient Name			**Primary Insurance**	
Social Security Number			Subscriber ID	
Date of Birth			**Secondary Insurance**	
Sex			Subscriber ID	
Street Address			**EMERGENCY CONTACT**	
Mailing Address			Contact Name	
Home / Cell Phone			Contact Phone	
PCP				
Pharmacy Name			**EMPLOYER INFORMATION**	
Pharmacy Phone			Employer Name	
Email		**Patient Portal Signup** ☐	Work Phone	
Responsible Party			Employer Address	
	Initial if correct ---------->			

OTHER PATIENT / FINANCIAL INFORMATION

The following information will help us tailor our services to better meet your needs and to obtain grants and other funds to continue improving our practice. Thank you in advance for your assistance.

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

Agriculture/Aquaculture

In the last two years, have you or anyone in your family worked in agriculture or aquaculture? ☐ Yes ☐ No

Agricultural/Aquaculture employment means:

- Preparing, irrigating, or spraying the fields, nurseries, or orchards;
- Planting, picking, sorting, packing, or transporting fruits, potatoes, tomatoes, other vegetables, grains, nuts, plants, tobacco, hops, flowers, alfalfa, hay, or other agricultural products;
- Planting trees, flowers, shrubs or working in a nursery;
- Work on farms that produce/breed animals such as chickens, ducks, turkeys, cows, goats, sheep, horses, cats or dogs;
- Work in aquaculture growing clams, oysters, scallops, or fish.

Have you or anyone in your family lived temporarily away from home within the last two years for agricultural/aquacultural employment? Examples are employer-provided housing, hotel/motel, apartment, rental home, labor camp, or car/truck/vehicle. ☐ Yes ☐ No

Do you or anyone in your family work in agriculture/aquaculture on a seasonal basis? ☐ Yes ☐ No

Seasonal employment means:

- Your hours changed from week to week
- Your income changed from week to week
- You were laid off for part of the year and had to do other work during that time.

Veteran

Have you previously served in any branch of the military (Army, Air Force, Coast Guard, Marines, Navy, National Guard and Reserves)? ☐ Yes ☐ No

Living Situation

Do you consider yourself homeless? ☐ Yes ☐ No
If you answered yes to the previous question, what best describes your current situation:
☐ Street/Outdoors (Car/Boat/Park/Tent/Abandoned Building) ☐ Doubling Up
☐ Transitional Housing ☐ Shelter ☐ Other

Household Income (annual)

☐ Greater than $50,000 ☐ $35,000-49,999 ☐ $25,000-34,999
☐ $15,000-24,999 ☐ $10,000-14,999 ☐ Less than $10,000

Number of household members supported by this income: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9+

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 the patient (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 patient. 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, or prescribe 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 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 provided in ESRHS dental offices: 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. I understand that student dentists may participate in my child's or own dental care and will be directly supervised by a licensed ESRHS dentist. Further, I understand that if I do not wish for student dentists to treat me or my child I will notify ESRHS. Please initial _____

E. For dental services provided in ESRHS Traveling Oral Health Program (TOP): I understand that the care provided to me or my child by an ESRHS Dental Hygienists practicing under remote supervision is not a substitute for the need for regular dental examinations by a dentist.

F. I understand that ESRHS has a 'No Show' policy (available upon request) and the patient is responsible for appropriately maintaining 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. Please initial _____

Protected Health Information (PHI) Patient Consent:

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.

G. I understand the ESRHS Notice of Privacy Practices (NPP) provides information about how ESRHS may use and disclose protected health information (PHI) about the patient. 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.

H. I consent to ESRHS' use and disclosure of PHI about the patient for treatment, payment, and health care operations. Examples of health care operations include, but are not limited to, prescriptions, laboratory, x-ray, referrals, electronic health information data exchange and consults with other health care providers. I have the right to restrict/revoke this consent, in writing; however, such a request shall not affect any disclosure ESRHS has already made in prior consent. Restrictions may negatively affect the timeliness of care. ESRHS is not required to comply with all restrict/revoke requests.

I. I authorize ESRHS to request and receive any records held by the Virginia Department of Health Professions or other appropriate state programs relating to Schedule II-V controlled substances dispensed to the patient.

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 the patient.

K. I consent to receive messages from ESRHS that utilize an automatic telephone dialing system to deliver a text, voice, or pre-recorded message that may contain health related information or healthcare management advice at the telephone number(s) that I have provided. I may request ESRHS to adjust my communication preferences at any time.

L. Guardianship: If applicable, I understand that I am the legal guardian of this patient and have provided official documentation to ESRHS.

M. If applicable: I authorize the release of all PHI about the patient 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**