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	
Primary Care Provider				
Pharmacy Name			**EMPLOYER INFORMATION**	
Pharmacy Phone			Employer Name	
Email		YES! Sign me up for the patient portal ☐	Work Phone	
Responsible Party			Employer Address	
	Initial if correct ---------->			

OTHER PATIENT / FINANCIAL INFORMATION	
The information below will help us better meet your needs and obtain funding to better serve our patients	
Race (check all that apply)	☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian ☐ Black or African American ☐ White ☐ Other Pacific Islander ☐ Decline to Specify
Ethnicity	☐ Hispanic ☐ Non-Hispanic ☐ Decline to Specify
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 or 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 ☐ Temporary 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 (give permission) for Eastern Shore Rural Health System, Inc. (ESRHS) to release (share) any information including the diagnosis and the records of any treatment or examination given to the patient (me or my minor child or ward named above), during the time care was received, to third party payers (entities that pay medical claims on behalf of the insured including insurance companies). I authorize and request third party payers to pay directly to the doctor/dentist's group benefits otherwise payable to me. I understand that my third party payers may pay less than the actual bill for services. I understand I must provide my insurance information within 45 days of the service or I will be responsible for the bill. I agree to pay for all services provided to patient. I accept full responsibility for any legal or collection agency fees, not to exceed 40%, if I don't pay my bill.

B. I give permission for ESRHS through its appropriate personnel to perform, give, or prescribe necessary examinations, tests, immunizations, injections and procedures. I have the right to decline treatment.

C. I understand Virginia state law (32.1-45.1) states that when a healthcare worker is exposed to bodily fluid of another person, the patient is considered to have given permission to be tested for hepatitis B, C and HIV and to release the results to the exposed person and the local health department.

D. I understand that ESRHS has a 'No Show' policy (available upon request) and the patient is responsible for coming to appointments on time. I understand that ESRHS has a list of patient rights and responsibilities available upon request. I understand my rights and agree to my responsibilities.

E. I agree 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.

F. Guardianship: If I have been granted legal guardianship of the person named above, I will provide official documentation to ESRHS.

G. I confirm that all information I have provided is true and correct to the best of my knowledge and believe that no facts have been left out.

Protected Health Information (PHI) Patient Consent:

ESRHS provides this section to comply with (follow) the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and applicable laws. ESRHS will protect PHI by complying with HIPAA regulations.

H. I understand the ESRHS Notice of Privacy Practices (NPP) provides information about how ESRHS may use and disclose (share) 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 get a revised copy by contacting ESRHS.

I. I agree to ESRHS' use and disclosure (sharing) of PHI about the patient for treatment, payment, and health care operations, except those requiring separate permission (such as substance use disorder patient records, 42 C.F.R. Part 2, and HIPPA, 45 C.F.R. Parts 160 and 164). 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 limit/cancel this agreement, in writing; however, such a request shall not affect any information ESRHS has already shared after I (the patient/parent/guardian) first gave permission.

J. I give permission to ESRHS to request, transmit, and receive any records held by the Virginia Department of Health Professions, RxHub National Patient Health Information Network and/or pharmacies as required to provide prescription services to the patient including Schedule II-V (controlled) substances

K. Optional: I give permission to share all PHI about the patient (except those restricted by law) to the individual(s) I listed below as well as allow those listed below to participate in patient care activities and approve necessary treatment for one year from the date below. I am responsible for notifying ESRHS if I wish to cancel these privileges.

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

This section applies to children being provided <u>dental services</u> in the ESRHS Traveling Oral Health Program or School-Based dental offices:

L. I give permission for ESRHS to provide routine dental care, such as examinations, x-rays, restorations (fillings), root canals, stainless steel crowns, cleanings, fluoride, space maintenance, and extractions with or without me being there. I authorize (give permission to) ESRHS to use pediatric dental care techniques such as voice control and timeout-per ESRHS policy (available upon request). I understand that if I do not wish for student dentists (supervised by a licensed ESRHS dentist) to participate and treat my child I will notify ESRHS. I understand that the care provided to my child by ESRHS Dental Hygienists supervised by a dentist in another location is not a substitute for regular dental examinations by a dentist. **(circle one) I AGREE I DISAGREE**

_____ _____ _____

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