PATIENT INFORMATION FORM

Patient Name: ____
(LAST) (FIRST) (MIDDLE)

DOB: _______________ Sex: (M) (F) EMAIL: ____
(EMAIL IS NOT USED FOR ADVERTISEMENT! Used for patient satisfaction survey only.)

Address: ____
(STREET) (APT #) (CITY) (STATE) (ZIP CODE)

Primary Phone: ____________________________ Ethnicity: ☐ Hispanic/Latino ☐ Other

Race: ☐ American Indian ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other

Emergency Contact: (Name and Phone #) ____

POLICY HOLDER EMPLOYMENT INFORMATION

Employer: ____ Occupation: _________________________

Address: ____ Phone #: ___________________________

PLEASE PROVIDE NAME AND ADDRESS OF POLICY HOLDER (PERSON THAT CARRIES INSURANCE) AND THE GUARANTOR (RESPONSIBLE) IF DIFFERENT FROM THE PATIENT

Name: _______________________________________ DOB: ______________ Phone #: _________________

Adress: ____
(STREET) (Apt #) (CITY) (STATE) (ZIP CODE)

INFORMATION CONCERNING MY MEDICAL RECORDS MAY BE RELEASED TO THE FOLLOWING AUTHORIZED PERSONS

Name: ____ Relationship: ____________________

Name: ____ Relationship: ____________________

Initial in space below to agree to the stament following the space.

______**CONSENT TO TREAT:** I consent to and authorize the physicians and other healthcare providers at ODC to perform scans/procedures ordered by my referring healthcare giver. I consent to any treatment or medication that may need to be administered to me during the scan/procedure by ODC physicians and other healthcare providers, if it is deemed medically necessary by their professional judgement.

______**PRIVACY NOTICE**: I acknowledge I have the right to receive, upon request, a copy of ODC's "Notice of Privacy Practices" which describes how ODC may disclose my protected health infromation (PHI). I understand that ODC/WCH does not need my permission to disclose health information for purposes related to treatment, payment, or routine business operations.

______**CONSENT TO CONTACT:** I acknowledge and agree that ODC may contact me at the phone number listed above. I consent to allow ODC/WCH to leave medical, billing or scheduling information on the voice mail/answering machine connected to the phone number listed above. I consent to ODC and WCH using my email information for patient survey purposes.

______**ASSIGNMENT OF BENEFITS:** I hereby authorize payment of all health insurance benefits to ODC/WCH. I understand the ODC is affiliated with WCH. I am aware that my billing statement will show Winnie Community Hospital as the billing entity. I also understand that I am legally responsible for all charges incurred wheather paid for by my health insurance or not. Any unpaid balance shall be due in full immediately if proceeds are paid directly to me.

______**HIV TESTING/ACCIDENTAL EXPOSURE:** Should a helathcare worker be exposed to any of my blood and/or other body fluids during my scan/procedure, I give my permission to be tested for HIV antibody and other communicable deseases.

I attest the above information is correct to the best of my kowledge. I have read and understand the content of this form.
I have had the opportunity to ask questions regarding the information on this form.
Signature (Patient/Parent/Guardian): ____ Date: ________________