



Chief Complaint/Consent

Patient Name: _____

Date: ____ / ____ / ____

Date of Birth: ____ / ____ / ____

Were you treated at this facility in the past year? Yes No

Will you provide a copy of your Advance Directive today? Yes No
Living Will/ Power of Attorney for Healthcare)

Primary Care Physician: _____

CHIEF COMPLAINT: (Primary reason for your visit today) _____

Is this complaint related to an Accident? Yes No

Date Accident Occurred: ____/____/____

Type of Accident: Work Related Auto Other

Accident Details: _____

Location of Occurrence: _____ City: _____ State: _____

Responsible Party: Name: _____ Contact Number: _____

How did you hear about us? Friend/Relative Website Commercial
 Magazine/Newspaper Billboard Other _____

Consent for Treatment * Use of Protected Health Information * Financial Obligation

I hereby consent to medical evaluations, testing, and/or treatment provided to me by the staff of this medical facility. I understand that this medical facility may use or disclose Protected Health Information (PHI) necessary to carry out treatment, payment, or healthcare operations. I authorize release of any information concerning me (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I acknowledge that I have received a copy of the facility Patient Rights/ Notice of Privacy Practices, Payment Policy, Resolution of Communication and Education Barriers and Advance Directive information. I understand that though I may have provided a copy of my Advance Directive, in an urgent care or emergency situation, it will not be honored unless specific direction is given by the provider on duty.

I acknowledge that if the provider has ordered additional laboratory test that the collected specimens will be sent to a local laboratory for testing. The facility will forward your payer information to the laboratory but you will be responsible for the charges incurred for these services and will receive a separate bill from the laboratory. I understand that there may be a portion of the cost of Durable Medical Equipment that is not covered by my insurance company and I will be responsible for the balance.

I hereby authorize the facility to accept assignment of insurance benefits and I understand that I am responsible for co-insurance, co-payments, and/or deductibles at the time of service. I understand that if my insurance is a non-contracted plan (out-of-network), the facility will courtesy file the claim for services rendered and any monies received by the facility will be reimbursed to me. In the event that I have no insurance coverage, I understand that fees are due at the time of service. I understand that the facility has the right to withhold discharge paperwork and prescriptions in the event of non-payment. I understand that previous balances owed to the facility will be requested at time of registration and any outstanding patient balance will be billed with accrued interest.

X _____
Signature of patient/guardian/accompanying adult

Date: ____ / ____ / ____