New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

Cedar Crest EmergiCenter® Airport Road EmergiCenter®

I, _____ understand that as part of my health care, Cedar Crest/Airport Road Emergicenter or Cedar Crest Imaging Center, David J. Shingles, D.O. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

1. A basis for planning my care and treatment,
2. A means of communication among the many health professionals who contribute to my care,
3. A source of information for applying my diagnosis and surgical information to my bill
4. A means by which a third-party payer can verify that services billed were actually provided, and
5. A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

1. The right to review the notice prior to signing this consent,
2. The right to object to the use of my health information for directory purposes, and
3. The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Cedar Crest/Airport Road Emergicenter or Cedar Crest Imaging, David J. Shingles, D.O. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Cedar Crest/Airport Road Emergicenter or Cedar Crest Imaging, David J. Shingles, D.O. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Cedar Crest/Airport Road Emergicenter or Cedar Crest Imaging change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's **treatment, payment, or health care operations,** it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

Patient's Signature Date

PATIENT INFORMATION

S.S.# _____

EXP# _____

Name _____ Age _____ Birth Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Marital Status _____ Spouse's Name _____

Address (if different than above) _____

Contact in Case of Emergency? _____ Phone _____

Is the patient a minor? ☐ yes ☐ no If yes, Parent Name _____

Parent S.S.# _____

Email Address: _____ Parent Date of Birth _____

INSURANCE INFORMATION

1. BC/BS State _____ GRP # _____ AGR # _____
   Subscriber Name _____ Date of Birth _____
2. Medicare ID # _____
3. Insurance Plan Name _____
   Address _____
   City _____ State _____ Zip _____ Birth Date _____

Subscriber _____ GRP # _____ ID # _____

Who is financially responsible for this bill? _____

EMPLOYER INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

Work Phone _____ EXT _____

PATIENT INFORMATION

Is this Workman's Compensation?	☐ Yes	☐ No
Is this an Auto Accident?	☐ Yes	☐ No
Is this a Pre-Employment Physical?	☐ Yes	☐ No
Do you have a Prescription Plan?	☐ Yes	☐ No
Do you want your Medical Records sent to your Doctor?	☐ Yes	☐ No

Who is your Family Doctor? _____

Who were you referred by? _____

I will be paying today by Cash _____ Check _____ Credit Card _____

I authorize payment of medical benefits to the undersigned physician or supplier for services rendered. I understand and agree that regardless of my insurance status I am ultimately responsible for the charges for any professional services rendered. I authorize the release of any medical information necessary for the payment of medical benefits.

_____ _____

Signature of Patient/Responsible Party Date