NOVANT HEALTH

Name: _____ _____ _____
(Last Name) (First Name) (Middle Initial)

DOB: _____ MRN#: _____

HAR#/DAR#: _____ CSN#: _____

Novant Health Medical Group

INFORMATION/CONSENT TO TREAT

PATIENT INFORMATION	Account #:	Medical Record #:	Date:
Patient name:		Referring doctor:	Referring doctor phone #:
Address:		Primary doctor:	
City/State/Zip:		Employer/School:	
(H) Phone #: Cell phone:	Work phone:	Email address:	
Date of birth:		Age: Marital status:	Sex:
Race:	Ethnicity:	Religion:	
Emergency contact (name):	Relationship:	(H) Phone #: (C)	
Responsible party:	Relationship:	DOB:	SS# (last 4 digits only): XXX-XX-
Responsible party address:		City/State/Zip:	Phone #:

INSURANCE INFORMATION			
Primary Insurance:	Employer:	Secondary Insurance:	Employer:
Insurance ID:#:	Insurance Group #:	Insurance ID #:	Insurance Group #:
Insured Name:		Insured Name:	
Address:		Address:	
City/State/Zip:		City/State/Zip:	
Insured DOB:	Insured SS# (last 4 digits only): XXX-XX-	Insured DOB:	Insured SS# (last 4 digits only): XXX-XX-

GENERAL CONSENT: I consent to medical care at Novant Health Medical Group. This includes needed lab work and HIV testing. By law, I understand that if there is an at-risk exposure to my blood or body fluids, I may be tested for HIV, Hepatitis B or C virus. Those test results will be shared with the healthcare worker who was exposed. I am aware that healthcare is not an exact science. No guarantees have been made. If I am hospitalized, I agree to send any valuables home. I agree that Novant Health Medical Group is not responsible for any loss or damage to my property.

FINANCIAL RESPONSIBILITY: I agree to pay for all medical services provided. I understand that I may need to call my insurance company to see if they will approve and pay for the medical care. I am aware that the doctors and others providing care may not be employees of Novant Health Medical Group. They are acting on their own and not at the direction of Novant Health Medical Group. I understand I will receive a separate bill for their services. Please bill my health insurance plan as a service to me. I am aware that this does not mean that they will agree to pay for any services. I agree to pay whatever amount is not covered. Please apply for any health insurance coverage that may be available to me. I agree to help in this process. I assign all of my rights and claims for payment under any health insurance plan to Novant Health Medical Group and any other treating providers. I appoint Novant Health Medical Group, the other treating providers and/or their agents as my "authorized representative" to act for me in getting payment for services provided. If I pay more than what I owe for this medical visit, I agree that it can be used to pay for any unpaid bills I have with any Novant Health Medical Group facility. I give permission to be contacted for treatment or payment purposes via any of the telephone numbers or email addresses I have given. This includes contact with a pre-recorded message, automatic dialing system, artificial voice, email message, or text message. Contact may also be made by businesses helping my providers collect money that I owe.

RELEASE OF INFORMATION: The undersigned hereby authorizes Novant Health Medical Group to disclose the patient's medical record or other medical information to any person or corporation which is or may be liable for all or part of the Novant Health Medical Group charges or to any person or corporation who has the responsibility for reviewing such charges, including but not limited to medical service organizations, health maintenance organizations, insurance companies, employers, welfare funds, or peer review organizations. The undersigned agrees the Novant Health Medical Group may copy medical record(s) which is/are to be sent to a receiving facility in the event the undersigned must be referred to another care provider/facility. The undersigned acknowledges and consents that the medical records, laboratory results, radiology reports and billing information may be sent or disclosed to another medical facility, physician office, or provider involved in the care of the patient or responsible for any part of the patient's charges.

*** For delivering mothers, all of these responsibilities apply to your newborn baby.**

I understand and agree with the above information. This consent is valid for three (3) years.

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

Patient Name (printed) _____ Representative Name (printed) _____

Relationship to Representative/ Authority to act on behalf of the Patient _____ Reason patient could not sign for him/herself _____

Signature of Patient or Representative _____ Date _____ Time _____

Witness Name (printed) _____ Date _____ Time _____

THIS FORM IS PART OF THE PERMANENT MEDICAL RECORD