Occupational Medicine/Workers Compensation Registration form

PATIENT INFORMATION		Date:		
Name:		Employer:		
Home address:		Work address:		
City/State/Zip:		Did you bring an authorization form? ☐ Yes ☐ No		
Home phone:	Work phone:	If no, who sent you?		
Social Security #:	Date of birth:	Age:	Driver's license: State: ___ #:_____	Sex:

WORKERS COMPENSATION PATIENTS ONLY:

Comp Carrier:	How did the injury occur?	Date of injury:
Address of carrier:		Type of injury:

OFFICE USE ONLY:		Account #:	Medical Record #:
Verified by:		Date:	
Employer fax #:		PAS:	
D/S required?	Alcohol testing required?	Other:	

Financial Responsibility:
I understand that my employer only will pay for authorized work-related exams, testing and treatment. I understand that I am personally responsible for all charges not covered by my employer. I understand that if I am here for treatment of an on-the-job injury and my workers compensation claim is denied then I am responsible for payment.

Consent for Healthcare and Release of Medical Information:
I voluntarily consent to healthcare treatment from the physicians and staff at this Novant Health facility. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatments or examinations by my caregivers. I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations. I have read this form. I have had the opportunity to ask questions and my questions have been answered.

Signature of Patient: _____ ***Date/Time*** _____

Acknowledgement of receipt of Joint Notice of Privacy Practices:
I have received a copy of the Novant Health Joint Notice of Privacy Practices. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice on Novant Health's website at www.novanthealth.org, by writing to the Privacy Officer, PO Box 33549, Charlotte NC 28233, or by requesting one at any Novant Health provider location.

Signature of Patient: _____ ***Date/Time*** _____

For Staff Use Only:
☐Patient refused to sign after he/she received the Joint Notice of Privacy Practices and was informed that signing the form merely acknowledges that the patient actually received the notice.
☐Patient was initially treated for an emergency condition. Patient either was given the notice after stabilization or will be given the notice after transfer. ***(Circle one)***

Signature of staff: _____ ***Date/Time*** _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:
☐ Interpreter Accepted _____ ☐ Interpreter Refused
(Name/Number of Person/Services Chosen/Used)