WILMINGTON HEALTH

Patient Information

Account No. _____

Doctor's No. _____

PLEASE ANSWER ALL QUESTIONS

PATIENT INFORMATION

NAME: LAST _____ FIRST _____ MIDDLE _____

BIRTHDATE _____ SS# _____

HOME PHONE _____

CELL PHONE _____

EMAIL ADDRESS _____

SEX ☐M ☐F

RACE ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Other Race ☐ American Indian/Alaskan

ETHNIC ORIGIN ☐ Hispanic ☐ Non-Hispanic

Language _____

ADDRESS _____ ADDRESS 2 _____

CITY _____ STATE _____

ZIP CODE _____ 4 DIGIT _____ COUNTY _____

COUNTRY _____ MARITAL STATUS _____

EMPLOYER _____ ADDRESS _____

WORK PHONE _____ EXT _____ PRIMARY CARE DOCTOR _____

INSURANCE INFORMATION

1) INSURANCE CO _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

MEDICARE/ID# _____

GROUP # _____

2) INSURANCE CO _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

MEDICARE/ID# _____

GROUP # _____

POLICY HOLDER INFO

NAME _____

RELATIONSHIP TO PATIENT _____

SS# _____

ADDRESS _____

CITY/STATE/ZIP _____

DATE OF BIRTH _____

EMPLOYER _____

ADDRESS _____

CITY _____ ST _____ ZIP _____

POLICY HOLDER INFO

NAME _____

RELATIONSHIP TO PATIENT _____

SS# _____

ADDRESS _____

CITY/STATE/ZIP _____

DATE OF BIRTH _____

EMPLOYER _____

ADDRESS _____

CITY _____ ST _____ ZIP _____

(1) I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the cost of the interest, collection and legal action (if required). (2) We are required by applicable federal and state law to maintain the privacy of your medical information. Our Notice of Privacy Practices document informs you of our legal duties, and your rights concerning your medical information. We must follow the privacy practices described in our notice. You may request a copy of our notice at any time. (3) My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Wilmington Health. This assignment covers any and all benefits under medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will insure such payment to Wilmington Health.

Patient Signature _____ Date/Time _____

Responsible Party Signature _____ Date/Time _____

AUTHORIZATION for USE and/or DISCLOSURE of PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information as described in Section B below**.** I understand that this authorization is voluntary.

I understand that, if the persons or organizations I authorize below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Section A: Patient Information (please print):

Name: _____

Address: _____

Account Number: _____ Social Security Number: _____

Date of Birth: _____ Telephone:_____

Section B: Protected Health Information to Be Used and/or Disclosed:

Do you wish for us to discuss all your protected health information with your family/friends or do you prefer that only specific information be released?

☐ All medical information, except psychotherapy information.

☐ Psychotherapy notes.

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information.

☐ Specific information (please describe): _____

_____

Entities Authorized to Use or Disclose: Wilmington Health

Families, Friends and Other Authorized to receive and Use: (please name specifically any family/friends to which we may release your protected health information either in writing or verbally):

_____ _____

_____ _____

SECTION D: Purpose of Use or Disclosure of Protected Health Information.

☐ So family member, friend or caregiver may have knowledge of or assist in my medical care or payment for medical care.

☐ At the request of the individual

☐ Other:_____

SECTION E: Expiration

This authorization will expire (complete one):

☐ Until I revoke permission in writing

☐ On the occurrence of the following event:_____

☐ 2 Years after my death

☐ Future Date ____/____/

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Wilmington Health Privacy Officer **Telephone:** (910) 796-7701
Fax: (910) 772-1307 **Address:** 1202 Medical Center Drive, Wilmington, NC 28401
E-mail: privacy @wilmingtonhealth.com

Inability to Condition Treatment: I understand that Wilmington Health may not condition my treatment on my refusal to sign this authorization.

Voicemail and Text Message Notifications

If you would like for us to leave medical information regarding your care (i.e. lab results) or appointments on an answering machine please complete the section below.

Wilmington Health may leave a message regarding my medical information on the answering machine at this number (_____)_____-_____

**Wilmington Health may send appointment reminders via text message to the following number (_____)_____-_____

☐ Wilmington Health may not communicate appointment reminders via text message

** Text messaging is an offered service, however not required for appointment reminder notification. Note Text messaging charges may apply, based on your service contract with your service provider.

I acknowledge that I have been made aware of Wilmington Health's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of the Wilmington Health Notice of Privacy Practices.

SIGNATURE—YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Signature: _____Date: _____

If this authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Include this authorization in the individual's medical record.