PATIENT INFORMATION

DATE: _____ CHART #: _____ Social Security #: _____

Patient Name: _____
LAST FIRST MIDDLE MAIDEN

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ ext. _____ DOB: _____

Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Child ☐ Legal Guardian

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Employer Name: _____ Employment Status: ☐ Full-time ☐ Part-time

Employer Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Student: ☐ Full-time ☐ Part-time

Parents: (if patient is a minor) Father's Name: _____ Date of Birth: _____

Mother's Name: _____ Date of Birth: _____

Referring Physician: _____

RESPONSIBLE PARTY INFORMATION

COMPLETE IF OTHER THAN PATIENT

Responsible Party Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ ext. _____ DOB: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Social Security #: _____ Employer Name: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Employment Status: ☐ Full-time ☐ Part-time

INSURANCE INFORMATION

INSURANCE ONE

Policyholder's Name (as it appears on card): _____ Policyholder's #: _____

Name of Plan: _____ Policy Group #: _____

Address to Mail Claims: _____ City: _____ State: _____ Zip: _____

Phone: ( ) _____ Effective Date: _____ Termination Date: _____

INSURANCE TWO

Policyholder's Name (as it appears on card): _____ Policyholder's #: _____

Name of Plan: _____ Policy Group #: _____

Address to Mail Claims: _____ City: _____ State: _____ Zip: _____

Phone: ( ) _____ Effective Date: _____ Termination Date: _____

INSURANCE THREE

Policyholder's Name (as it appears on card): _____ Policyholder's #: _____

Name of Plan: _____ Policy Group #: _____

Address to Mail Claims: _____ City: _____ State: _____ Zip: _____

Phone: ( ) _____ Effective Date: _____ Termination Date: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ ext. _____

Relationship to Patient: _____

CABARRUS MEMORIAL HOSPTIAL
D/B/A NORTHEAST MEDICAL CENTER

Authorizations and Notifications

TREATMENT: The undersigned hereby consents for the physician and staff of Cabarrus Memorial Hospital d/b/a NorthEast Medical Center or any of its subsidiaries (hereinafter collectively referred to as "NEMC") to administer treatment deemed advisable for the patient. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made as to the result of treatment or examination.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I give permission to release any medical information about my treatment (including copies of my medical records) needed for payment of my insurance claim, or for my continuing care after I have been treated. I also give permission to use medical information about my treatment for quality assurance review purposes. I reserve the right to revoke this consent at any time and I understand my revocation will be effective no earlier than the date of my notice.

PAYMENT OF CO-PAYS AND CO-INSURANCE: I understand that NEMC is committed to providing me with the highest quality care possible. I also understand that NEMC is committed to controlling costs. I acknowledge that I have a responsibility to assist with controlling costs by paying my co-pay at the time of each service, or paying my co-insurance amount at the time of each service.

FEES FOR NON-CANCELLED VISITS: I understand that it is my responsibility to give my provider at least 24 hours notification if I cannot keep a scheduled appointment. If I do not provide adequate notification I will be charged for the missed appointment. I further understand that the missed appointment fee is my responsibility and my insurance carrier will not be billed.

MEDICARE-MEDICAID CERTIFICATION: I have given correct information on my application for payment under Titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act. I ask that any authorized Medicare and/or Medicaid benefits be paid on my behalf, for any physician or other services furnished to me by NEMC. I give permission to NEMC to release any of my medical or other information needed by Medicare, Medicaid and their respective agents, in order to determine the benefits to which I am entitled.

NON-COVERED SERVICES: I understand that my physician may recommend that certain tests be performed to assist in his/her treatment/diagnosis of my medical condition. My insurance carrier may not cover the tests my physician feels are necessary for treatment/diagnosis. If my physician thinks the tests may not be covered by my insurance payor, I will receive advance notification and will be asked to sign a waiver stating that I accept responsibility for payment. I also understand that I have the option to decline having the tests performed.

ASSIGNMENT OF INSURANCE/LIABILITY BENEFITS: I hereby authorize payment directly to NEMC and all physicians involved in my treatment or diagnosis at NEMC by the group insurance, major medical insurance, hospital, surgical, medical, and any other insurance payable to or on behalf of the undersigned, by virtue of treatment of the below named patient. I unconditionally assign any insurance benefits to NEMC and all physicians involved in my treatment and further authorize them to apply any surplus insurance benefits or any other payments received from any source, to the payment of other unpaid bills of the below named patient or of the undersigned or any individual who is financially responsible for the patient or guarantor. I understand that I am financially responsible to NEMC and physicians for charges not paid by insurance. If an unpaid balance is sent to a collection agency, I will be responsible for any legal fees, expenses, and/or interest associated with collection of the debt.

REFERRALS AND AUTHORIZATIONS: I realize that my physician may recommend that I receive additional treatment from a specialist, and that my insurance carrier may require that my primary care provider complete a referral and/or authorization for such treatment. I acknowledge that it is my responsibility to make sure the specialist has received the completed referral/authorization prior to my scheduled appointment with the specialist. If the referral/authorization is not completed prior to the visit, I will be required to pay for the visit in full at the time of service.

By signing this document I acknowledge that I have read, understand, and will comply with its contents.

Patient Signature (Date)

Responsible Party if not Patient (Date)