PATIENT INFORMATION	Account #:	Medical Record #:	Date:
Patient Name:		Referring Doctor:	
Address:		Referring Doctor Phone #:	
City/State/Zip:		Primary Doctor:	
(H) Phone #: (C)	Work Phone:	Employer/School:	
Social Security #:	Date of Birth:	Age:	Marital Status:	Sex:
Emergency Contact:	Relationship:	(H) Phone #: (C)	
Responsible Party:	Relationship:	DOB:	SS#:
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 Social Security #:	Insured DOB:	Insured Social Security #:

Financial Responsibility and Assignment of Insurance Benefits:

I guarantee payment to Statesville HMA Medical Group, LLC and its affiliates (Statesville HMA Medical Group, LLC) of all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits, which would otherwise be payable to me, to Statesville HMA Medical Group, LLC for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct.

Consent for Healthcare and Release of Medical Information:

I voluntarily consent to healthcare treatment ("Treatment") from the physicians and staff at Statesville HMA Medical Group, LLC facility. I consent to any necessary lab work, including HIV testing. 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 or Authorized Person: ______________________ ***Date/Time:*** ______________

Insured Party or Financial Guarantor (if different from above): ______________________ ***Date/Time:*** ______________

Acknowledgement of Receipt of Joint Notice of Privacy Practices:

I have received a copy of the Statesville HMA Medical Group, LLC 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 by writing to the Privacy Officer, PO Box 3250, Mooresville, NC 28117, or by requesting one at any Statesville HMA Medical Group, LLC provider location.

Signature of Patient or Authorized Person: ______________________ ***Date/Time:*** ______________

For Staff Use Only

☐ Patient refused to sign after he/she received 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.

(Check 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)

STATESVILLE HMA MEDICAL GROUP, LLC

Outpatient Information / Consent to Treat