Novant MEDICAL GROUP

Outpatient 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:	
Social Security #:	Date of birth:	Age:	Marital status:	Sex:
Race:	Ethnicity:	Religion:	
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 #:

General Consent: I consent to medical care at this facility. This includes needed lab work and HIV testing. I am aware that healthcare is not an exact science. No promises have been made. By law, I understand that if there is an at-risk exposure to my 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.

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. 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. I appoint Novant Health 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 facility. I give permission to be called on any of the telephone numbers I have given. This includes calls with a pre-recorded message, automatic dialing system or artificial voice. Calls may be made by businesses helping Novant Health collect money that I owe.

I understand and agree with the above information. This consent is valid for one (1) year.

Signature of Patient or Authorized Person: _____ ***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)