Outpatient Information / Consent to Treat

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 Novant Health and its affiliates (Novant Health) 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 Novant Health 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 this Novant 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.

Would you like information on advance directives? ☐ ***Yes*** ☐ ***No***
(Living Will, Health Care Power of Attorney, Advance Instruction for Mental Health Treatment, Organ Donation)

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 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 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. ***(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)