PATIENT INTAKE FORM

PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle Name:_____

Age:_____ Date of Birth:_____ ☐ Male ☐ Female SSN:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home phone:_____ Work Phone:_____ Cell phone:_____

Spouse's Name:_____ Contact Phone:_____ **Email address**_____

EMPLOYMENT INFORMATION

Employer: _____

Occupation:_____

EMERGENCY CONTACT

Contact name:_____ Contact phone: _____

Contact name:_____ Contact phone: _____

IF MINOR, NAME OF PERSON RESPONSIBLE FOR PAYMENT: _____

Relationship to Minor:_____ Primary Phone: _____ Work Phone: _____

Resp. Party Address: _____

SSN: _____ Date of Birth: _____

Employer:_____ Occupation:_____

INSURANCE INFORMATION ☐ *I DO NOT HAVE INSURANCE*

Insurance carrier:_____ Insured name: _____

Policy number:_____ Group number:_____

2nd Insurance carrier:_____ Insured name: _____

Policy number:_____ Group number:_____

CONSENT FOR TREATMENT

By signing below, I hereby consent to the provision of care, diagnosis and/or treatment by Malheur Memorial Health Center and I hereby acknowledge that such consent will remain in effect unless and until I cancel such consent in writing.

ASSIGNMENT OF INSURANCE INFORMATION AND BENEFITS

By signing below, I hereby authorize the insurance carrier listed above to make payments directly to the Health Care Provider and understand that I am financially responsible for all charges incurred that are not covered in full by my insurance. I further understand that if I enroll in another insurance plan, it is my responsibility to notify Malheur Memorial Health Center; otherwise, I am responsible for payment.

Patient Signature:_____ Date:_____

MM HC

MALHEUR MEMORIAL HEALTH CENTER

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR MALHEUR MEMORIAL HEALTH CLINIC

Patient Name: _____

DOB: _____

Today's Date: _____

By signing below, I am acknowledging that:

I am either the patient or the patient's personal representative.

I have been offered a copy of the "Notice of Privacy Practices" (NPP); and

I understand that I may contact the person named in the NPP if I have questions about the content.

___ I have requested a hard copy of the NPP.

_____ _____

Signature of patient or parent/legal guardian/legally responsible person Date

_____

Description of relationship to patient

TO BE COMPLETED BY STAFF

Complete all applicable parts—Please refer to instructions

Part 1. Complete if signature requested but not obtained:

Staff member provided Notice of Privacy Practices to patient; and

Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:

____ Patient/personal representative refused to sign form

____ Other _____

Part 2. Complete if patient/personal representative unavailable to sign form on first date of service delivery:

___ Form mailed/sent to patient/personal representative on _____ (mm/dd/yyyy).

Part 3. Complete if either Part 1 or Part 2 completed:

_____ _____

Signature of staff member Date

MMHC (Revised 06/2013)
MMHD (Reviewed 06/2013)

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patients Name:_____ Phone:_____

Address:_____

Purpose of Consent: by signing this form, you will consent to our use and disclosure of your protected health information (PHI) to carry out treatment, payments and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy before you decide whether to sign this consent. Our notice provides a description of our treatment, payments, and healthcare operations; it also describes the uses and disclosures we may make of your protected health information and of other important matters about your health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your PHI that we maintain.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person in our office. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation.

I,_____ have had full opportunity to read and consider the contents of this consent for and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my PHI to carry out treatment, payments and healthcare operations.

I hereby give my consent to release my health information to the following people (**family/friends you give us permission to discuss/release your PHI to**):

1._____ Relationship/Phone:_____
2._____ Relationship/Phone:_____
3._____ Relationship/phone:_____
4._____ Relationship/phone:_____

Patients Signature:_____ **Date:**_____

_____

If Patient a Minor: Signature of Parent/Legal Guardian/ Legally Responsible Person

Signature: _____ **Date:**_____

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

Representative's Name:_____ **Date:**_____

REVOCATION OF CONSENT

I revoke my consent for your use and disclosure of my PHI. I understand that my revocation of my consent will not affect any action you took in reliance on my consent before you received this notice.

Signature:_____ **Date:**_____

This will stay in effect for 1 year.