Randolph Health Medical Group

Today's Date _____ Patient Number _____

Patient Information

Name _____
Last First Middle Maiden

Mailing Address _____
Street City State Zip

Physical Address _____
(if differs from above) Street City State Zip

Telephone Number (____)_____ Cell Phone Number (____)_____ Email Address _____

Date of Birth _____ Social Security Number _____
mm/dd/year

(Circle One)

Sex: Male Female Status: Minor Single Married Separated Divorced Widowed

Race: White Black Asian Alaskan Native American Indian Other _____

Hispanic Ethnicity: Yes No Primary Language _____

Employer _____ Phone Number (___)_____

Address _____
Street City State Zip

Emergency Contact: Name _____ Telephone Number (___)_____

How did you hear about us? □ Friend □ Internet □ Newspaper □ Phonebook □ Referral Physician □ Other _____

Person Responsible for Bills (Guarantor) ***Please complete this section if other than self***

Name _____
Last First Middle Maiden

Mailing Address _____
Street City State Zip

Telephone Number _____ Relationship to Patient _____

Date of Birth _____ Social Security Number _____
mm/dd/year

Alternate Emergency Contact Information (Other than Household Member or Self)

Name _____
Last First Middle Maiden

Address _____
Street City State Zip

Telephone Number _____ Relationship to Patient _____

Please continue on back side

Insurance Information

(1) Primary Insurance Company Name _____

Policy Holder Name _____ Policy Holder Employer _____
(as listed on card)

Policy Number _____ Group Number _____

**If Policy Holder is not the Guarantor or the Patient, please complete the following:

Policy Holder Social Security Number _____ Policy Holder Date of Birth _____

Relationship of Patient to Policy Holder _____

••••••••••••••••••••••••••••••••••••

(2) Secondary Insurance Company Name _____

Policy Holder Name _____ Policy Holder Employer _____
(as listed on card)

Policy Number _____ Group Number _____

**If Policy Holder is not the Guarantor or the Patient, please complete the following:

Policy Holder Social Security Number _____ Policy Holder Date of Birth _____

Relationship of Patient to Policy Holder _____

••••••••••••••••••••••••••••••••••••

(3) Third Insurance Company Name _____

Policy Holder Name _____ Policy Holder Employer _____
(as listed on card)

Policy Number _____ Group Number _____

**If Policy Holder is not the Guarantor or the Patient, please complete the following:

Policy Holder Social Security Number _____ Policy Holder Date of Birth _____

Relationship of Patient to Policy Holder _____

Randolph Health
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Insurance Benefit Assignment/Guarantee of Payment/Use of PHI/Consent for Treatment/
Power of Attorney/Acknowledgment

Patient's Name: _____ **DOB:**_____

Insurance Assignment and Medicare/Medicaid Certification:

I, the undersigned, hereby authorize payment of health insurance benefits that I am entitled to per my benefits contract with my insurer to be paid to Randolph Health Medical Group. This authorization will include those major medical benefits payable to the physician who rendered care on my behalf.

As a Medicare/Medicaid patient (if applicable), I hereby authorize payment of all claims filed by the above referenced provider of healthcare services, which are otherwise payable to me. I hereby authorize the provider of healthcare services to release any health information that may from time to time be required by Medicare/Medicaid in order to make final determination of payment of claims submitted by the provider for all medically necessary services rendered to me. I certify that the information given by me in applying for payment under Titles XVII and XIX of the Social Security Act is correct.

As the signer below, I attest that RHMG has been requested to maintain my signature on file for the purpose of filing claims permitted by the assignment.

Guarantee of Payment:

I, the undersigned, hereby acknowledge that I am the guarantor on this account and, as such, will be responsible for payment of charges not covered by my health insurer. Once my healthcare insurer makes a final claims determination as reflected on their Explanation of Benefits received by my healthcare provider, I understand payment of the remaining balance is immediately due. RHMG does not discriminate based on ability to pay.

RHMG, as a tax deferred entity, is required by IRS code to offer patients with legitimate financial need a sliding fee schedule. Upon your request, RHMG will require specific documents from you in order to determine if you qualify for our sliding fee schedule based on your income. You, our patient and/or guarantor on the account, have the ultimate responsibility of making a request for sliding fee scale consideration and will be expected to provide RHMG with any and all documentation required to make an accurate determination of income. The amount of discount afforded the patient/guarantor will vary and be based on income as determined by RHMG.

Reasons we may use and disclose Protective Health Information (PHI) without your authorization:

RHMG, as the provider of healthcare services, is authorized to release, without prior authorization, any PHI required to:

1. Provide health care treatment to you, including communicating with other health care providers to coordinate and manage your health care
2. Obtain payment for services rendered
3. Perform business activities known as "health care operations" in order to collect information for such purposes as: improving the quality, efficiency and cost of care that we provide.

Other circumstances for providing PHI without your authorization include, but are not limited to, public health activities or when required by law. See our Notice of Privacy Policies for further details.

Consent for Medical Treatment

I, the undersigned am knowingly requesting general medical services from RHMG and I am requesting these services willingly and voluntarily. By my signature below, I attest that I am eighteen (18) years of age or older, of sound mind, and not constrained nor under undue influence. I understand that my physician will be responsible for providing me with an explanation of current information regarding my diagnosis, treatment and prognosis (as applicable) and will require my consent on any procedures performed on me. My physician will ensure that I am adequately informed and understand the reasons for the procedure. I understand that I have the right to refuse such care, except in an emergency.

Power of Attorney Regarding Healthcare Services Rendered to a Minor:

As the legal guardian of the patient who is under the age of eighteen (18) years of age and who does not possess statutory authority to make his/her own decisions regarding healthcare services rendered, I authorize the following persons to make these decisions in my absence and convey in listing them the legal authority to make such decisions.

Power of Attorney, as described herein, is hereby granted to the following individuals:

Name	Relationship to Patient	Date
Name	Relationship to Patient	Date
Name	Relationship to Patient	Date

Acknowledgement as Signer on the Account:

Upon my signature below, I attest that I have read and understand all the provisions discussed herein. Any questions I have asked have been answered to my satisfaction and to the extent where I can place my signature on this document. In doing so, I convey and acknowledge a full understanding of my rights and obligations as a patient of RHMG. Should the patient be a legal minor as defined in the State of North Carolina Statute, I hereby attest as the signer below, that I am the lawful guardian of the minor.

Signature of Patient/Guarantor on the Account	Date
Relationship if Other than Patient	Date

Reason Patient Cannot Sign

Witness	Date

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Acknowledgement of Receipt of Privacy Notice

Patient Name: _____ **Date of Birth:** _____

I have been presented with a copy of the **Notice of Privacy Practices**, detailing how my information may be used and disclosed as permitted under federal and state law.

I understand the contents of the Notice of Privacy Practices:

Signed: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____

Witnessed by (staff): _____ **Date:** _____

Complete this section only if there are individuals (spouse, children, friends, family) that you would like to list as persons whom you grant us permission to share your health information with, including information related to treatment, billing and healthcare operations.

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Internal Use Only:

If unable to obtain acknowledgement of receipt of notice, please document the date and time the notice was presented to patient or patient's representative and sign below.

Presented on (date and time): _____

By (name and title): _____

[ ] The patient declined to sign the acknowledgement

[ ] The patient was undergoing emergency treatment

[ ] Other _____