

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 (name):	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 Novant Health. This includes needed lab work and HIV testing. By law, I understand that if there is an at-risk exposure to my blood or 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. I am aware that healthcare is not an exact science. No guarantees have been made. If I am hospitalized, I agree to send any valuables home. I agree that Novant Health is not responsible for any loss or damage to my property. I understand and agree with the above information. This consent is valid for three (3) years.

Patient or Responsible Person Signature: _____ **Date** _____ **Time** _____

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. I am aware that the doctors and others providing care may not be employees of Novant Health. They are acting on their own and not at the direction of Novant Health. I understand I will receive a separate bill for their services. 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 and any other treating providers. I appoint Novant Health, the other treating providers and/or their agents 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 contacted for treatment or payment purposes via any of the telephone numbers or email addresses I have given. This includes contact with a pre-recorded message, automatic dialing system, artificial voice, email message, or text message. Contact may also be made by businesses helping my providers collect money that I owe. I understand and agree with the above information. This consent is valid for three (3) years.

Patient or Responsible Person Signature: _____ **Date** _____ **Time** _____

* For delivering mothers, all of these responsibilities apply to your newborn baby.

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

Interpreter Accepted

Interpreter Refused

(Name/Number of Person/Services Chosen/Used)