

**Outpatient Information / Consent to Treat**

<b>PATIENT INFORMATION</b>		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 #	
<b>INSURANCE INFORMATION</b>					
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 SS #		Insured Name	Insured SS #	

**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 Medicaid 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 results 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, Healthcare Power of Attorney, Advance Instruction for Mental Health Treatment, Organ Donation)

<b>Signature of Patient or Authorized Person</b>	Date/Time
<b>Insured Party or Financial Guarantor</b> (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](http://www.novanthealth.org), by writing to the Privacy Officer, PO BOX 33549, Charlotte, NC28233, or by requesting one at any Novant Health provider location.

<b>Signature of Patient or Authorized Person</b>	Date/Time
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**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)

<b>Signature of Staff</b>	Date/Time
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If limited English proficient or hearing impaired, offer interpreter at no extra cost:

Interpreter accepted \_\_\_\_\_  Interpreter refused

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