New Patient Information

Please Print

Last Name: ___________________________First Name: ___________________________ MI: _______

First Name Used:____________________ DOB:____________________ Sex: ☐Male ☐Female

Mailing Address: ___________________________________City/State/Zip: _________________________

Physical Address: __________________________________City/State/Zip: _________________________

Summer Address: __________________________________City/State/Zip: _________________________

Home Phone: ___________________ Cell: ____________________ Work: _________________________

May we send you reminders by text? ☐Yes ☐ No

If we are unable to contact you personally, may we leave a healthcare related message such as test results, referrals, etc… on you answering machine? ☐Yes ☐ No Patient's Initials_____________

Birth State:______________________ Marital Status: ☐M ☐S ☐W ☐D

Race: ☐Caucasian ☐American Indian/Alaskan ☐African American ☐Asian ☐Pacific Islander

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino Primary Language: ______________________

Employer: ____ Phone: ___________________________

Email Address: _____________________________________

Financial Responsible Party:

Name: _______________________________ DOB:___________________ SSN:____________________
Relationship to Patient: ☐Father ☐Mother ☐Legal Guardian ☐Power of Attorney

Mailing Address: ___________________________________City/State/Zip: _________________________

Home Phone: ___________________ Cell: ____________________ Work: _________________☐OK to text

In Case of Emergency, please notify the following person:

Name:__________________________________ Relationship to Patient: ___________________________

Home Phone: ___________________ Cell: ________________________ Work: ______________________

Please be sure to present your insurance card(s) at check-in on each visit.

Medical Insurance Information: **☐Self-Pay**

Primary Insurance:____________________________ Policy Holder: ________________________________.

Policy Holder DOB:_______________ Policy Holder Relationship to Patient:_________________________

ID#_____________________________ Group# __________________ Effective Date:___________________

Secondary Insurance:_________________________ Policy Holder: ________________________________.

Policy Holder DOB:_______________ Policy Holder Relationship to Patient:_________________________

ID#_____________________________ Group# __________________ Effective Date:___________________

Do you currently have a Living Will in place? ☐Yes ☐ No

Do you have a Medical Power of Attorney? ☐Yes ☐ No

If yes, please provide a copy to our office to keep on file.

Preferred Pharmacy: ▫ Wickenburg Community Hospital Pharmacy ▫ Other ____________________________

Patient/Guarantor Signature:_________________________________ Date:___________________________

Community Hospital Clinic, Wickenburg, 523 Rose Lane, Wickenburg, AZ 85390
Community Hospital Clinic, Congress, 26750 B. Santa Fe Road, Congress, AZ 85332
Community Hospital Clinic, Wittman, 32919 Center St, Wittman, AZ 85361

PATIENT LABEL

SERVICE AGREEMENT

CONSENT TO MEDICAL AND SURGICAL PROCEDURES

I voluntarily consent to diagnostic procedures and medical treatment deemed necessary by authorized providers and employees of the hospital and clinic staff.

NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES

I acknowledge I have been offered a copy of a Statement of Patient Rights and Responsibilities ensuring that I am treated with respect and dignity and without discrimination or distinction based on age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law.

I received a copy of the Patient Bill of Rights. _______________Patient initials

I declined a copy of the Patient Bill of Rights. _______________Patient initials

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered the hospital's Notice of Privacy Practices which describes the ways in which the hospital may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures and I understand that I may contact the hospital's Privacy Officer, designated on the notice, if I have a question or complaint.

I received a copy of the Notice of Privacy Practices. _______________Patient initials

I declined a copy of the Notice of Privacy Practices. _______________Patient initials

PRESCRIPTION HISTORY CONSENT

I voluntarily consent to provide Community Hospital Clinics access to and use of my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years. I acknowledge that Community Hospital Clinics may use health information exchange systems to electronically transmit, receive and/or access my prescription history. I understand that this Prescription History Consent will be valid and remain in effect as long as I attend or receive services from Community Hospital Clinics, unless revoked by me in writing with such written notice provided to each practice site I attend or from which I receive services.

Patient initials:__________

PERSONAL BELONGINGS

I understand and agree that the Wickenburg Community Hospital and Community Hospital Clinic shall not be liable for the loss or damage to any money, jewelry, glasses, dentures, hearing aids, electronic devices, other hardware or any other articles of financial or personal value that may be bought into the hospital by visitors during your stay.

Patient initials:__________

FINANCIAL AGREEMENT

I agree that for the services provided to the patient by hospital, clinic and other health care providers, I will pay the account balance of the patient or make financial arrangements satisfactory to the hospital, clinic or any other providers, prior to discharge.

I understand the hospital is required to provide a screening examination to all patients who are seeking medical services to determine if there is an emergency medical condition, without regard to the patient's ability to pay. If there is an emergency medical condition, the hospital will provide stabilizing treatment within its capacity. I understand the hospital has a financial assistance policy and the financial responsibility for these services may be reduced or waived for those who qualify.

I understand that should my account become delinquent, it may bear interest at the legal rate and if my account is referred to an attorney for collection, I am responsible to pay reasonable attorney fees and collection expenses.

Patient initials:__________

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Community Hospital Clinic, Congress, 26750 B. Santa Fe Road, Congress, AZ 85332
Community Hospital Clinic, Wittman, 32919 Center St, Wittman, AZ 85361

Wickenburg Community Hospital

PATIENT LABEL

RELEASE OF INFORMATION

In consideration for the treatment to be given by Wickenburg Community Hospital and Community Hospital Clinics, I hereby agree to the confidentiality of medical records relating to this service including, without limitation, any psychiatric treatment. For the time period of this service, I agree, understand and authorize all records generated by this treatment and/or admission to the hospital (or treatment for whom the undersigned has legal authority to execute this consent form) can be reviewed by any person or organization authorized by law. I also authorize that these records can be reviewed by and released to a third party payer who may provide insurance payment to the hospital or clinic. Provider may release any and all parts of the patient's medical records to persons or entities engaged in the activities stated below:

A. Insurance and Quality Review: Persons or corporations (including insurance companies, worker's compensation payers, hospital or medical service corporations, welfare governmental agencies, or the patient's employer), or their designees, which may be liable under contract to the Provider, other party, patient, family member, or employer of the patient, for the purposes of securing payment for all or part of a Provider's charges, quality assurance, accrediting agencies, and provider/ physician liability insurance carriers to enable them to carry out their functions.
B. Billing and Collections: Agents or employees of the Provider that process or duplicate medical records for billing and reimbursement purposes.
C. Medical Audit: Persons or entities authorized by the Provider for purposes of conduction medical audit activities.
D. Other Providers: Physicians and personnel involved in the patient's care to provide and manage the patient's health care. Also, information may be given to other health care providers to assure continuity of care.
E. State or Regional Health Information Exchange, currently the Health Information Network of Arizona.

Patient initials:__________

This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION** (except psychotherapy notes), **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines below.

Patient initials:__________

ASSIGNMENT OF BENEFITS

I irrevocably assign and transfer to the hospital all rights, benefits, and other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment shall include allocating and authorizing direct payment to the hospital of all insurance and health plan benefits payable for hospitalization or for outpatient services. I agree that the insurer or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with, and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment.

Patient initials:__________

For Medicare/Medicaid Beneficiaries Only: I certify that the information given by me in applying for payment under Titles XVIII & XIX under the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf for any service furnished to me by, or in Wickenburg Community Hospital and Community Hospital Clinics, including physician services. I authorize any holder of medical or other personal information to release any information necessary to determine these benefits or related services to the health care financing administration and agents.

Patient initials:__________

PATIENT/GUARANTOR SIGNATURE

I, the undersigned, as the Patient, Patient Representative, or legal guardian of a minor/incapacitated Patient, hereby certify I have read, and fully understand this Conditions of Admission and Authorization for Medical treatment, and that I have signed this Conditions of Admission and Authorization for Medical Treatment knowingly, freely, voluntarily and agree to be bound by its terms.

Patient	Patient Name / MR#
Witness	Guarantors
Date	Relationship to Patient

Community Hospital Clinics Cancellation and No-Show Policy

Our goal at Community Hospital Clinic is to provide you with Quality health and Wellness Services, and to provide those services in a timely manner that is convenient for you as our patient and also the community we serve. Any late cancellations or missed appointments (No-Shows) prevent other patients from receiving needed care and services.

In order to maintain our high standard of care, we ask that you **arrive 15 minutes early** to your appointment, **30 minutes early if you are a new patient.** ***If you must change your appointment, please contact our scheduling department 24 hours in advance*** at (928) 668-1833 and we will be happy to assist you. If the office is closed, or an operator/receptionist is unavailable, please leave us a voicemail message with your date of birth, first and last name, telephone number and we will promptly return your call to reschedule your appointment.

Missed appointments or "No Shows" are when an appointment is missed without cancelling. Failure to show for an appointment is recorded in our system and will be subject to the following:

First No Show - A Letter will be mailed.

Second No-Show - You will be charged a fee of $75 which would have to be paid before another appointment could be scheduled for you.

Third No-Show – You will be charged $75 which would have to be paid prior to your next visit and you will only be allowed to schedule same day appointments. Please note that same day appointments are subject to availability.

Continued No-Shows could result in you being discharged from our clinics.

By Signing below, you acknowledge that you have read and understand this Cancellation and No-Show policy.

______________________________ ______________________________

Print Name Date

______________________________ ______________________________

Signature Witness

520 Rose Lane, Wickenburg, AZ 85390
HIM Phone: 928-684-4364 HIM Fax: 928-684-9406

Authorization to Disclose Health Information

Patient Name: ______________________________ Date of Birth: __________

Address: ____________________ City: ______________ State: ________ Zip: ________

Phone: ____________________ Email Address: ____________________________

I Hereby Authorize:

____
(Name of person or facility)

____
(Address)

____
(Phone) (Fax)

To Release To:

____
(Name of person or facility)

____
(Address)

____
(Phone) (Fax)

Date(s) of Service: __________________

Type of Release:

☐Hard Copies (paper) ☐Verbal Exchange (no copies) ☐Review of Record (no copies)

☐Okay to Leave Message at #______________ ☐Other Please Specify: __________________

Health Information to be Released:

☐ALL Medical Records ☐Laboratory Reports ☐Radiology Reports ☐Radiology Images

☐Cardiac/EKG Reports ☐Surgery Reports ☐Immunizations ☐Medications

☐Other: ____

Authorization to Release Protected Information: **Required – Complete the check boxes below indicating how protected information should be handled even if the categories do not apply to requested medical records.*

Check one: ***Initial each line:***

____DO/ ___ DO NOT Release **Alcohol and/or Substance Abuse Records** ______

____DO/ ___ DO NOT Release **Genetic Testing Records** ______

____DO/ ___ DO NOT Release **HIV/AIDS & Other Communicable Disease Test Results Records** ______

____DO/ ___ DO NOT Release **Behavioral Health/Mental Health/Psychiatric Treatment Records** ______

Authorization/Revocation:

This authorization will terminate in one year. I understand that I may stop this release at any time by writing to the WCH HIM department. Once the health information has been released to another facility or provider, there is no way to cancel or stop the release. I understand that when the health information is released the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that WCH will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form. I understand that I must sign this form to release my heal information.

X______________________________
Signature

X______________________________
Date

____
Relationship to patient (if not patient)

140-2018-004