Wickenburg Community Hospital

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:_____

Wickenburg Community Hospital, 520 Rose Lane, Wickenburg, AZ 85390
Community Hospital Clinic, Surgeons, 519 Rose Lane, Wickenburg, AZ 85390
WCH Bagdad Physical Therapy, 700 Palo Verde, Bagdad, AZ 86321

Wickenburg Community Hospital

PATIENT LABEL

CONDITIONS OF ADMISSION

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.

LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS

I understand some providers and surgeons providing services to me, including Emergency Room Physicians, Hospitalists, Surgeons, Anesthesiologist and others, are not employees, representatives or agents of the hospital. They are independent practitioners who have been granted the privilege of using the hospital for the care and treatment of their patients. **Professional services rendered by independent practitioners are not part of the hospital bill. I understand that I may be billed separately for these services.**

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

PATIENT DIRECTORY

Emergency Department (ED) or Inpatient ONLY: In order to assist family members and other visitors in locating you while you are in the Hospital, we maintain a patient directory that includes your name and room number. We will disclose this information to someone who asks for you by name, unless you instruct us not to.

I opt out of the ED/Inpatient Directory. Patient initials:_____

PRESCRIPTION HISTORY CONSENT

I voluntarily consent to provide Wickenburg Community Hospital 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 Wickenburg Community Hospital 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 Wickenburg Community Hospital revoked by me in writing with such written notice provided to each practice site I attend or from which I receive services.

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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Wickenburg Community Hospital

PATIENT LABEL

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:_____

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