Patient Demographics

LITTLE RIVER HEALTHCARE

Patient Information

Name (Last, First, MI) _____ Age: _____ Driver's License #: _____

Address: _____ City/State/Zip: _____

Home Phone #: _____ Cell Phone #: _____ Social Security #: _____

Date of Birth: ____ / ____ / _____ Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Referring Provider: _____ Referrer's Phone #: _____ Pharmacy: _____

Advanced Directive: ☐ Yes ☐ No ☐ I would like information about advanced directives; Organ Donor: ☐ Yes ☐ No

Is this visit the result of an accident? ☐ Yes ☐ No ☐ Other: _____

Patient's Employer: _____ Occupation: _____

Address: _____ City/State/Zip: _____

Work Phone #: _____ E-Mail Address: _____

Guarantor Information

Responsible Party: _____ Social Security #: _____ Relationship: _____

Date of Birth: ____ / ____ / _____ Address: _____ City/State/Zip:_____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Guarantor's Employer: _____ City/State/Zip: _____

Emergency Contact Information

Nearest Relative: _____ Relationship: _____Home Phone #: _____

Employer: _____ Work Phone #:_____

Notify in Case of Emergency: _____ Relationship: _____

Address: _____ City/State/Zip: _____ Phone #: _____

Financial / Insurance Information

MUST PRESENT INSURANCE CARD/FORMS, DRIVER'S LICENSE AND SOCIAL SECURITY CARD

METHOD OF PAYMENT: ☐ Cash ☐ Worker's Comp ☐ Commercial Insurance ☐ Medicare ☐ Medicaid

Primary Insurance Carrier: _____ Type of Insurance: ☐ HMO ☐ PPO ☐ POS ☐ Other

Policy #: _____ Group Name/ Group #: _____ Effective Date: ____ / ____ / _____

Employer: _____ Policy Holder Name: _____

Policy Holder Date of Birth: ____ / ____ / _____ Policy Holder's Social Security #: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

LITTLE RIVER HEALTHCARE
www.LRhealthcare.com

Patient Signature: _____

Date: _____ / _____ / _____

Patient Consent Agreement

LITTLE RIVER HEALTHCARE

Authorization for Care: I grant permission to the employees of Little River Healthcare to examine, treat, and perform diagnostic tests and procedures that my provider deems necessary.

Authorization of Care by ANP/PA: I understand that my care may be provided by an Advanced Nurse Practitioner or Physician Assistant in consultation with a physician. Arrangements will be made for referral to a physician if medically indicated or at my request. There may or may not be a doctor of medicine or osteopathy present in the hospital 24 hours per day, seven days a week. My signature on this form constitutes my consent to treatment by this professional.

Assignment of Benefit: Insurance Assignment: In consideration of services rendered or to be rendered, I hereby assign and transfer to Little River Healthcare any benefits payable for my benefit under hospitalization, sickness or accident insurance, and any other insurance coverage, to include major medical, for the payment of services rendered. This assignment includes insurance benefits accruing to me from uninsured motorist coverage.

Financial Agreement & Responsibility: I understand that, regardless of my assigned benefits, I am responsible for all charges. I understand that Little River Healthcare may file a claim for benefits on my behalf but, whatever my coverage, it is a personal contract between me and my insurance company. If benefits are not paid, I will be billed for the entire balance which I must pay in full upon receipt of the statement. I understand that I am responsible for charges not covered by this assignment and / or not paid by said companies and payers.

Medicare Lifetime Authorization: By signing below, I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration of the intermediaries or carrier any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and requested payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I further understand that I will assume full responsibility for any Medical costs not covered by Medicare.

Patient Medicare # _____

Non-Smoking Facility: I understand this is a non-smoking facility and I will abide by this policy.

Valuables: I understand that Little River Healthcare is not responsible for personal items (dental items, eye wear, jewelry, clothing, etc.) electively kept in my room or designated area while I am a patient. I further understand that patient care items left in the room following discharge will be disposed of and not replaced by Little River Healthcare.

Photography/Imaging: I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Little River Healthcare will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Little River Healthcare's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

HIV, HBV and HCV Testing After an Accidental Exposure: Texas law authorizes a hospital or physician to require that a patient be tested for possible exposure to the Human Immunodeficiency Virus, Hepatitis B virus and Hepatitis C virus in the following situations: (1)if donation of blood, blood products, organs or tissues is contemplated; (2) if a health care worker is accidentally exposed to a patient's blood or bodily fluids, such as through a needle stick; or (3) if a medical surgical procedure is to be performed which could expose health care workers to the patient's blood or bodily fluids. This disclosure is to inform you that you may be tested if any of these situations occur during your hospitalization. I consent to HIV, HBV & HCV testing under any of the above situations.

Privacy Practices: Little River Healthcare is required by law to maintain the privacy of a patient's protected health information (PHI). In addition, we are required by law to provide individuals with a notice of our legal duties and privacy practices, if requested, with respect to PHI.

Please indicate how we may contact and leave messages for you:

Home telephone, answering machine or voice mail	☐ Yes	☐ No
Cell Phone and/or Voice Mail	☐ Yes	☐ No
Work Phone, answering machine or voice mail	☐ Yes	☐ No

Patient Rights and Responsibilities: I have been given the opportunity to review my rights and responsibilities as a patient. I understand my rights because they have been explained to me and my questions have been answered.

Authorization to Release Information: By signing below, I authorize Little River Healthcare to release information requested by insurance companies, review agencies or other third party payers for payment of claims arising out of this visit.

Please list the names of authorized individuals that can receive protected health information: _____

_____	_____	_____
Signature of Patient or Patient's Representative	Date & Time	Representative's Relationship to Patient
_____	_____	
Witness Signature	Date & Time	

PLACE STICKER HERE