Community Healthcare System
CARE NETWORK

PLEASE PRINT

TODAY'S DATE	PATIENT REGISTRATION	MRN #:

PATIENT INFORMATION

LAST NAME				FIRST NAME & INITIAL			
PATIENT SS#		SEX	M / F	DATE OF BIRTH		MARITAL STATUS	MARRIED / SINGLE
PREFERRED LANGUAGE		RELIGION				PLACE OF WORSHIP	
ADDRESS							
CITY				STATE		ZIP	
PRIMARY CONTACT #	☐ HOME PHONE		☐ WORK PHONE			☐ CELL PHONE	
E-MAIL ADDRESS							
EMPLOYER		EMPLOYER'S ADDRESS					
OCCUPATION		SIZE OR # EMPLOYEES	1-19 / 20-99 / 100 +		EMPLOYMENT STATUS	FULL TIME / PART TIME / RETIRED / STUDENT	
SPOUSE'S NAME							
SPOUSE'S HOME PHONE		SPOUSE'S WORK PHONE			SPOUSE'S CELL PHONE		

ETHNICITY: ☐ NO, NOT HISPANIC ☐ YES, HISPANIC OR LATINO

RACE: ☐ AMERICAN INDIAN ☐ ALASKAN NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ WHITE OR CAUCASIAN ☐ OTHER
☐ PATIENT REFUSED

NAME OF PRIMARY INSURANCE:

POLICYHOLDER LAST NAME		FIRST NAME & INITIAL			RELATIONSHIP		
ADDRESS					CONTACT PHONE		
POLICY HOLDER SS#		SEX	MALE / FEMALE		POLICY HOLDER DATE OF BIRTH		
EMPLOYER		EMPLOYER PHONE			EXT.		
EMPLOYER ADDRESS					SIZE OR # EMPLOYEES	1-19 / 20-99 / 100 +	

NAME OF SECONDARY INSURANCE:

POLICYHOLDER LAST NAME		FIRST NAME & INITIAL			RELATIONSHIP		
ADDRESS					CONTACT PHONE		
POLICY HOLDER SS#		SEX	MALE / FEMALE		POLICY HOLDER DATE OF BIRTH		
EMPLOYER		EMPLOYER PHONE			EXT.		
EMPLOYER ADDRESS					SIZE OR # EMPLOYEES	1-19 / 20-99 / 100 +	

EMERGENCY CONTACT INFO

NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU					RELATIONSHIP		
ADDRESS							
PRIMARY CONTACT #	☐ HOME PHONE		☐ WORK PHONE			☐ CELL PHONE	

YOU MUST READ AND SIGN THE OTHER SIDE OF THIS FORM

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CARE NETWORK

PT. NAME: MRN #:

Authorization for Treatment – I hereby authorize the physician to conduct such examinations, perform such procedures as are medically required, and administer such treatment and medication as deemed necessary or advisable. I hereby certify that I have read and fully understand this Authorization form. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Release of Information/Medical Record Diagnosis – I hereby authorize the physician(s) providing services and any other authorized person to release to its authorized billing agents, any physician who treated me, my insurance carrier, employer's workmen's compensation insurance company, or other category of third party payor, the Social Security Administration under Title XVIII (18) of the Social Security Act, the Professional Review Organization, or other intermediaries responsible for payment of my charges, a complete report of services rendered including diagnosis, findings, and details of treatment and progress for the purpose of receiving payment for the services rendered. I understand that I may revoke this consent at any time by giving written notice. I understand that if I refuse to consent to the release of information, I will be held personally responsible for payment of all charges for services rendered.
I give my permission to Community Healthcare System and all clinical providers who have provided care to me, along with any billing service, collection agencies, attorney or other agents who may work on their behalf, to contact me on my cell phone and/or home phone using automatic telephone dialing systems or other computer assisted technology.

Authorization for Assignment of Benefits / Financial Obligation – In consideration of medical services provided, I hereby assign and transfer to the physician all of my rights, title and interest to medical reimbursement, including, but not limited to, the right to designate a beneficiary, add dependent eligibility and to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by my physician, including Medicare Part B. I understand that I will be fully responsible for payment of any and all charges not covered by medical insurance. I understand that if I do not pay the balance in full my account will be placed for collection and I will be responsible for all collection expenses including reasonable attorney's fees and court costs. It is our policy to charge a fee for any check that is returned due to Insufficient Funds.

Co-payments – I understand that if my medical insurance requires a co-pay or encounter fee the payment is due AT THE TIME OF SERVICE.

No Show Policy – Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences. Due to high patient demand, and limited availability of appointments we have instituted a **$35 no show fee. You must give 24 hour advanced notice to cancel appointments. Failure to do so will result in a $35 fee charged to your account. By signing below, I acknowledge that I have read and understand this policy.**

Precertification –If my insurance requires precertification it is my responsibility to make sure it is obtained. I will be held financially responsible if the precertification is not obtained.

Advance Directive – Information regarding advance directives is provided in the Patient Information Guide.

H.H.S. Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of NOTICE OF PRIVACY PRACTICES:

Patient Signature	Date	Responsible Party Signature	Date
Witness Signature	Date	Relationship to Patient	

(Section 1) I give consent & authorization for the medical, or billing staff of my physicians office to release information regarding my medical care to:

_____ (Name/ Relationship) _____ (Name/ Relationship)

_____ (Name/ Relationship) _____ (Name/ Relationship)

(Section 2) AUTHORIZATION TO REQUEST SERVICE OR TREATMENT OF A MINOR

I give my consent and authorization for persons I list below to have the right and priviledge to request service and treatment for all minors listed on the other side of this form, should I not be present or available by telephone. This authorization is subject to revocation at any time and must be done in writing, except to the extent that action has already been taken in reliance on the consent.

Name_____ Relationship_____

Name_____ Relationship_____

I understand I may revoke this privilege listed in (Section 1) and (Section 2) at any time by submitting my request in writing to this office.

Patient/Parent/Guardian Signature _____ DATE _____

ADVANCED DIRECTIVE

Have you appointed a Health Care Representative? yes ____ no____ Do you have a living will? yes ____ no____

Have you given anyone your Power of Attorney? yes ____ no____