Four Oaks Medical Clinic

Patient Registration/Demographics

Drivers Licenses/ID Provided: Yes No	**Insurance Card Provided** Yes No
Today's Date:	**Primary Care Provider:**

PATIENT INFORMATION

Patient Last Name:	**First:**	**Middle:**
Is this your LEGAL name if not, what is your LEGAL name:		**Sex: M F**
Date of Birth:	**Social Securty Number:**	
Phone Number:		
Marital Status (Circle one): Single Married Divorced Separated Widowed		

PHYSICAL/MAILING ADDRESS

Street Address: (Apartment, Suite, Unit, Building, Floor, Trailer Number)	City:	State:	Zip Code:
Mailing Address: (P.O. Box)	City:	State:	Zip Code:

RACE/ETHNICITY:

Race: African American American Indian Asian Caucasian Hispanic Other
Ethnicity: Hispanic Non-Hispanic
U. S. Citizen: Yes No

EMPLOYER INFO:

Occupation:	Employer:	Phone Number:
Workplace Injury?		
Do you have a Power of Attorney: Yes No	Do you have an Advance Directive: Yes No	
EMAIL address:		
Preferred Pharmacy:		

IN CASE OF EMERGENCY:

Emergency/Preferred Contact Person:	Relationship to Patient:
Home Phone Number:	Work Number:

MINOR-PARENT INFORMATION

Name:	Relationship:	Phone Number:	
Social Security Number:	DOB:		
Mailing Address: P.O. Box	City:	State:	Zip Code:

FOUR OAKS MEDICAL CLINIC
AUTHORIZATION/CONSENT FORM
CONSENT FOR TREATMENT

_____ Initials	I hereby voluntarily consent to care encompassing diagnostic procedures and medical treatment by my physician, his assistants or his designees, as may be necessary in his judgment. I acknowledge that no guarantees have been made as to the result of treatments and examination. I agree to be medically attended and treated.
_____ Initials	I agree to services provided by Medical Students &/or Residents. Medical Students and Residents function under the direct supervision of a Physician. I agree to services provided by Allied Health Students. Allied Health Students function under the supervision of the appropriate department manager. Students/Residents may participate in your care at a level consistent with their level of training.
_____ Initials	I agree to HIV and other communicable disease testing in the events of a healthcare worker being exposed to my blood or body fluids.
_____ Initials	I agree to have photographs taken of appropriate parts of my body in order to provide supporting documentation of my medical condition. I understand that any photographs taken will be placed in and remain part of my medical record.
_____ Initials	I agree to services provided by Mid-level providers. A Mid-level provider (Nurse Practitioner &/or Physician Assistant) is not a Physician, but does function under the supervision of a Physician either directly or via protocols established by a Physician.
_____ Initials	Four Oaks Medical Clinic may utilize generative AI transcription technology to generate medical notes and update a patient's medical chart in real-time. Natural language processing allows the transcription software to analyze and dictate human conversations as they occur, like a physician's scribe. The technology can be used during or after the patient's visit when a doctor prepares after-visit summaries and updates a patient's chart.

AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE INFORMATION

I consent to the use of disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare, and to conduct health care operations. I understand my treatment may be contingent upon consent as evidenced by my signature on this document.

I understand I have a right to review the Notice of Privacy Practices before signing this document. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations. <u>This may include release of my protected health information to another provider in the event of consultations or referrals.</u> The Notice of Privacy Practices also describes my rights and duties with regard to my protected health information.

AGREEMENTS, AUTHORIZATIONS, & IRREVOCABLE ASSIGNMENTS

Financial Agreement and Assignment of Benefits:

I promise to pay for the services rendered at Columbus Community Hospital (hereinafter referred to as CCH) in accordance with the rates and terms now in effect at this hospital to the extent I am legally responsible for such payment. I hereby assign to CCH, provision of care and treatment, any an all benefits, interest, and rights (including causes of action and the right o enforce payment for services rendered under any insurance policies or any reimbursement or prepaid healthcare plan). I further understand and agree that any and all conditions of recovery of benefits remain in my sole responsibility, and this in no way relieves me of my personal obligation to pay for services rendered at CCH.

This form has been explained to me and I certify that I understand its contents.

_____ _____
Patient or Legally Authorized Representative/Relationship Date

_____ _____
Witness Date