Medical Record #_____

Adair County Medical Clinics
Fontanelle, Greenfield, and Stuart

Patient Name_____ Date of Birth _____ Sex ___M ___ F

Address _____ SSN_____Home Phone _____

City _____State_____ Zip _____ Cell Phone _____ Work Phone_____

Marital Status ___Single ___Married ___Divorced ___Separated ___ Widowed **Advanced Directive ____Y _____N**

Employer _____

Employer's Address _____ Employer Phone # _____

Spouse's Name _____ Spouse's SSN _____ Spouse's DOB _____

Spouse's Employer _____ Spouse's Employer's Phone _____

If patient is a minor please complete the following:

Mother's or: Name_____ Date of Birth_____Social Security Number_____

(Guardian) Address_____Home Phone_____

Employer:_____Employer Address_____Work Phone #_____

Father's or: Name_____Date of Birth_____Social Security Number_____

(Guardian) Address_____Home Phone_____

Employer_____Employer Address_____Work Phone #_____

Notification of Results - Please initial next to the following that you authorize your permission to the Adair County Medical Clinic to leave a message concerning protected health information by the following method:

_____ Leave a message on answering machine

_____ Leave a message with: Name _____ Phone _____

Name _____ Phone _____

_____ Send an email e-mail address_____

_____ Send a Letter _____ Other (specify) _____

Consent to Treatment: I hereby give my consent to the physician in charge of my care to administer any treatment, diagnostic testing, therapy sessions, or any other care deemed necessary or advisable in my treatment unless otherwise specified by myself or my designee.

Assignment of Benefits: I hereby assign all benefits and authorize direct payment to Adair County Medical Clinic of all insurance and Medicare benefits payable for my care not to exceed the hospital's regular charges or the payer's allowable benefits. I understand I am fully responsible to pay for charges incurred but not covered by this agreement. I agree that any credit balance resulting from payment of insurance or other sources to the hospital may be applied to any other account owed to the health system by me.

Privacy Notice Acknowledgement

Adair County Health System's (ACHS) privacy notice provides information about how we may use and disclose protected health information about you and states your rights with respect to your medical information. ACHS has the right to revise these information practices and amend the Notice of Privacy Practices. In the event of a change you may obtain a revised copy by requesting one from the hospital registration or business office. A revised notice will be posted in the registration office.

I acknowledge that I have received a copy of ACHS Notice of Privacy Practices.

Signature_____ Date_____

Witness _____ Date_____