INJURY CARE REGISTRATION

First Name	Middle	Last Name (include Jr., Sr. III, etc.)	Today's date

ADDRESS

STREET/PO BOX: _____

CITY _____ STATE: _____ ZIP: _____

CONTACT INFORMATION

Home Phone No: _____ _____

Mobile Phone No: _____

Work Phone No: _____

Birth Date: _____

Social Security Number: _____

MARITAL STATUS:

◯ Single

◯ Married

◯ Divorced

◯ Widow/Widower

EMERGENCY CONTACT

Name: _____

Telephone Number: _____

Relationship: _____

CONSENT FOR ELECTRONIC PRESCRIBING

Our practice uses an electronic system to send prescriptions between our office and your pharmacy. This system may allow your health care provider to see information about medications that you are already taking that may have been prescribed by other health care providers. By signing this form you agree to allow your health care provider to use the electronic prescribing system to view this information.

_____

Patient Signature

DEMOGRAPHIC INFORMATION

Our office participates in a federal program that requires us to record demographic information about our patients, including preferred language, race and ethnicity.

DEMOGRAPHIC INFORMATION – LANGUAGE

Please indicate your preferred language.

◯ English

◯ Spanish

◯ Other (specify): _____

DEMOGRAPHIC INFORMATION – RACE

Please select one or more to indicate your race. You may decline to answer this question.

◯ American Indian/Alaska Native

◯ Asian

◯ Black or African American

◯ Hispanic or Latino

◯ Native Hawaiian/Other Pacific Islander

◯ White

◯ I decline to answer

DEMOGRAPHIC INFORMATION – ETHNICITY

Please indicate your ethnicity. You may decline to answer this question.

◯ Hispanic or Latino

◯ Not Hispanic or Latino

◯ I decline to answer

CRESTWOOD
WORKERS CARE

7736 Madison Blvd • Huntsville, AL 35806
256-830-8930 • *fax* 256-830-8932

General Consent for Treatment

I consent to have treatment or physical examination/ testing performed by the physician, nurse practitioner and professional staff at Crestwood Workers Care. I permit the provider to treat me in ways they judge are beneficial to me. I understand that this care may include examinations, x-rays, other tests, and the drawing of my blood.

Consent is given by: ☐ Patient ☐ Other
Patient unable to consent because: _____.
I, therefore, consent for the patient.
Relationship to patient: _____.

☐ Yes ☐ No
I give permission for my medical information to be communicated to me via phone numbers listed in my chart. The following individuals may receive my medical information over the phone:_____

☐ Yes ☐ No
I give permission for my medical information to be left in the form of a voicemail.

☐ Yes ☐ No
I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Signature: _____ Date: _____

HIPAA Privacy Act

I hereby acknowledge that I have been provided with a copy of the notice of Privacy Practices of Crestwood Workers Care.

Signature of Patient or Authorized Party: _____
Date: _____
Time: _____ ☐ AM ☐ PM

If above signature is other than Patient, relationship to patient: _____

Interpreter, if utilized: _____

1ROI

All portions of this form ***must*** be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient's Name _____ Date of Birth _____ Medical Record Number _____

Address _____ City, State, Zip _____ Telephone Number _____

I authorize the use and disclosure of health information about me as described below:

Facility Authorized to Release my Health Information _____

Agency or Individual(s) Authorized to Receive my Health Information _____

Address _____ City, State, Zip _____ Telephone Number _____

Health Information that may be used / disclosed is limited to the following: ❑ Progress Notes ❑ Emergency Room Record
❑ Discharge Summary ❑ History & Physical ❑ Consultation(s) ❑ Lab ❑ Pathology Report
❑ Operative Note(s) ❑ Imaging/X-ray ❑ X-ray Reports ❑ Entire Record ❑ Other *(specify)*_____

Health Information that may be used / disclosed is limited to the following periods of healthcare:
From (date): _____ To (date): _____ Account Number: _____
From (date): _____ To (date): _____ Account Number: _____

Health information to be released to the above named agency / individual is to be used / disclosed for the following purpose(s):
❑ Treatment/Consultation ❑ At Request of Patient ❑ Research ❑ Marketing ❑ Billing or Claims Payment
❑ At Request of Employer ❑ Other_____

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, ***to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses*** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

If applicable, I agree to the release of my medical or billing records containing the **sensitive information** listed above. ❑ Yes ❑ No

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically *expire 60 days* after the date of signature below (except as indicated above), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Insurance Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

Patient's or Authorized Personal Representative's Signature* _____ Date _____ Time _____

Relationship to Patient / Authority to Act on Patient's Behalf _____ Interpreter, if Utilized _____

Witness's Signature _____ Expiration Date or Event _____

❑ **Signature validated against driver's license or signature in Medical Record. There may be a charge for copying Medical Records.*

Authorization to Use and Disclose
Protected Health Information
HIM-1401G (Revised 07/10, 11/10) Page 1 of 1
WHITE - Medical Record CANARY - Recipient

Patient Label