St.Vincent

Patient Demographic Information Form

Please fill out every space. If it does not pertain to you, please write N/A, for Not Applicable.

Patient Information

Patient's Name (Last, First, Middle) (Suffix) (Preferred) (Former Last Name)

If patient is a child, Parent's Names

Sex ☐ Male ☐ Female

Date of Birth

Social Security #

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Separated ☐Partner

Address **City** **State** **Zip code**

Home Phone **Mobile Phone** **Work Phone**

Patient Email

Preferred Language **Race** **Ethnicity**

❑ Hispanic ❑ Non-Hispanic

Provider Information

Primary Care Physician **Referring Provider**

Communication

❑ I authorize St.Vincent, and those parties acting on behalf of St.Vincent, to contact me about appointments and reminders for health services via: ❑Home Phone ❑Mobile Phone ❑Email

Is it OK to leave medical information on your answering machine or voice mail? ❑Yes ❑No

Guardian

Name (Last, First, Middle, Suffix)

Emergency Contact Information

Name **Relationship**

Home Phone # **Mobile Phone #**

Employment

Employer's name **Phone**

Address **City** **State** **Zip code**

Guarantor

Patient's Relationship to Guarantor			
Name (Last, First, Middle, Suffix)		**Date of Birth**	
Address	**City**	**State**	**Zip code**
Employer		**Social Security #**	

Insurance

Primary Insurance Company	Subscriber's Name (Policyholder)
Subscriber's DOB	Relationship to Subscriber
Secondary Insurance Company	Subscriber's Name (Policyholder)
Subscriber's DOB	Relationship to Subscriber

Clinical Information

Preferred Pharmacy
Preferred Lab

Financial and Treatment Consent

By signing my name below:

- I hereby guarantee payment in full within thirty (30) days of all charges established by St.Vincent Health for services rendered to me or my dependent, unless other arrangements satisfactory to St.Vincent Health have been made. This includes any charges that a third-party payer may determine to exceed usual and customary limits.
- I understand and acknowledge that if any unpaid amounts owed by me are assigned to a third party for collection, I will be responsible for paying attorney fees, interest, court costs, and other costs of collection, including but not limited to collection agency fees.
- I authorize Medicare, Medicaid, all relevant commercial payers to pay St.Vincent Health on my behalf for any services furnished to me or my dependent. I certify that I have read this assignment of benefits, that the information given by me is correct, and that I agree to all of the provisions contained in it.
- I understand that if I am facing financial difficulty I can apply for financial assistance from St.Vincent Health.
- The insurance information I have provided is current and correct. If I sign this form and the insurance card is found later to be outdated or invalid, I understand that I am responsible for paying for the services in full and will need to file with the insurance carrier myself.
- I hereby consent to treatment by my St.Vincent Health Provider(s). I understand that St.Vincent Health will release to my referring or subsequent healthcare provider, reports of my medical condition that will assist him or her in my continuing care and as needed to process claims and for general health care operations. I agree that this Consent is valid for all treatment and payment of said treatment for a period of twelve (12) months following execution of the Consent.
- I understand my insurance co-pay is due at the time of service, per my insurance company policy.

I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES:_____(Patient's Initials)

_____ _____

Patient/Guarantor/Guardian Signature Date

OFFICE USE ONLY NPP Witness/Issued by: _____

St.Vincent

PATIENT CONSENT TO SHARE PROTECTED HEALTH INFORMATION

*This form will allow us to leave a message on voicemail or with individuals involved in your health care

PATIENT INFORMATION:

Name of Patient:	**Phone Number:** **Other Number:**
Date of Birth:	**Address:**
Provider/Office Name:	**Office Location/Address:**

I (the undersigned) hereby consent to St.Vincent Health leaving a voicemail message at the number(s) indicated above and /or discussing with the individual(s) listed below information related to my protected health information (PHI). These communications may include, but are not limited to, appointment reminders, medications, pre-registration, billing and insurance items, and any information pertaining to clinical health services, such as laboratory and test results. I understand that this consent is only valid at the office location listed above.

With my consent, St.Vincent Health may discuss my PHI with the following individuals:

Name:	Date of Birth:
Relationship:	Phone #:
Name:	Date of Birth:
Relationship:	Phone #:
Name:	Date of Birth:
Relationship	Phone #:

I understand the information listed above may be communicated via: fax, photocopy, verbal communication, telephone, voice mail and/or direct mail.

If certain information is NOT to be included, please list:_____

YOUR RIGHTS WITH RESPECT TO THIS CONSENT:

I understand that I have the right to revoke this consent at any time by sending a written statement to the St.Vincent Health office location above, except to the extent St.Vincent Health has already made a disclosure in reliance upon my prior consent. Unless revoked, this consent is valid until the expiration date listed below. A photocopy of a signed consent is acceptable, provided that it is apparent that the consent was signed and dated prior to photocopying.

I further understand that this consent does not permit the release of my actual medical records to the individual(s) listed above. Such release will only be made if I sign a separate valid authorization.

If I fail to specify an expiration date, event or condition, this consent will be valid for one year. _____

Expiration Date / Event / Condition

_____ _____

Signature of Patient or Legal Representative — Date

_____ _____

(If signed by Legal Representative, state relationship and authority to do so) — Signature of Witness

Patient is: ❑ **Minor** ❑ **Incompetent** ❑ **Disabled** ❑ **Deceased**

Legal Authority: ❑ **Custodial Parent** ❑ **Legal Guardian** ❑ **Executor of Estate of Deceased**

❑ **Authorized Legal Representative** **Received by:**_____ **Date:**_____