

PATIENT REGISTRATION – EMPLOYER REQUESTED SERVICE

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

STREET/PO BOX: _____

CITY _____ STATE: _____ ZIP: _____

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.

CONTACT INFORMATION

Home Phone: _____

Mobile Phone No: _____

Work Phone: _____ Work Fax: _____

EMAIL ADDRESS _____

DEMOGRAPHIC INFORMATION – LANGUAGE

Please indicate your preferred language.

English

Spanish

Other (specify): _____

Date of Birth: ____/____/____ Age: _____
month day year

Social Security Number: _____

Male Female Single Married

Divorced Widow/Widower

Company Requesting Services: _____

Supervisor: _____

Reason for Today's Visit: _____

DEMOGRAPHIC INFORMATION – RACE

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

American Indian or Alaska Native

Asian

Black or African American

Hispanic or Latino

Native Hawaiian or Other Pacific Islander

White

I decline to answer

ID CONFIRMED

PHOTO ID

COMPANY REPRESENTATIVE

NAME

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

- **Consent for specimen collection and release of information related to DOT Drug & Alcohol Testing results are covered through separate federally-mandated processes.**
- **Please inform the staff of any special needs you may have during the specimen collection process.**
- **Crestwood Workers Care will not be responsible for loss of or damages to your personal property while you are in the clinic.**



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
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WHITE - Medical Record CANARY - Recipient

Patient Label