APPALACHIAN
Regional Medical Associates
A Division of Appalachian Regional Healthcare System
at The Cardiology Center

Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

# Patient Information Update

Please Print Name: First:_____ M/I_____ Last:_____ Date: ____/____/____

Gender: ☐Male ☐Female

Date of Birth: _____/ _____/ _____ Social Security Number: _____/ _____/_____

Mailing Address: Street-_____

City-_____ State-_____ Zip Code-_____

Home Phone#: _____ Work Phone#: _____

Cell#: _____ Email: _____

Employer/ Occupation: _____

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

Initial _____☐

## Consent for Medical Treatment

Knowing that I am seeking medical care/medical testing, I hereby voluntarily consent to such medical care encompassing diagnostic procedures and medical treatment by my physician, his/her assistants or his/her designees as may be necessary in his/her judgment. I am aware that the practice of medicine and surgery is not an exact science and I acknowledged that no guarantees have been made as to the results of treatments or examinations in the hospital/practice. This form has been fully explained to me and I certify that I understand its contents to my satisfaction.

Initial _____☐

## Assignment of insurance benefits

I hereby authorize direct payment of surgical and medical benefits to the physician or to whomever he/she designates and I also authorize direct payment of all other benefits to ARHS and its subsidiaries. The benefits referred to herein would be payable to me if I did not make assignment and include major medical insurance. I understand to my satisfaction that I am personally responsible to practice and physician respectively for charges not covered by this agreement. I also authorize ARHS and my attending physician to release any medical information required in processing of applications for final coverage for services rendered.

Initial _____☐

## Medicare-Medicaid Patient's Certification

I do hereby authorize ARHS and its subsidiaries to release information and request payment. I certify that the information given by me in applying for payment under Titles XVIII and XIX of Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.

Initial _____☐

## Notice of Privacy Practices and the Financial Information

I have had the opportunity to review and ask questions about the notice of Privacy Practices and the Financial Information brochures.


Effective Date: 06/15/2015
Revised Date: 09/19/2016
Form Number: 10982

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*Patient Information Update*

Initial

## 3rd Party Billing Agreement

_____ ☐ I acknowledge and understand that in addition to a bill from Appalachian Regional Medical Associates, patients who accept the services for pathology, laboratory, or imaging will receive a separate bill from the respective service provider.

Initial

## Consent to Receive Communication on Cell Phone

_____☐ I do hereby authorize ARMA and its subsidiaries to call my cell phone to communicate with me or to leave a message for me for financial reasons such as balance due, new insurance and financial assistance as well as appointments, wellness checkups, pre-registration, lab results, and any other healthcare related information.

**My cell phone number is:** _____

ARMA may also send me messages via:

☐ Email: _____ ☐ Other_____

**Release of Medical and/or Financial Information: Persons authorized to receive information**

Name: _____ Relationship:_____ Phone: _____
☐Medical (i.e. results of lab tests/ x-rays) ☐Appointment information ☐Financial ☐Other

Name: _____ Relationship:_____ Phone: _____
☐Medical (i.e. results of lab tests/ x-rays) ☐Appointment information ☐Financial ☐Other

Name: _____ Relationship:_____ Phone: _____
☐Medical (i.e. results of lab tests/ x-rays) ☐Appointment information ☐Financial ☐Other

This release may be revoked upon written request of the patient or legal guardian. This release will also be revoked if the patient transfers care to another provider outside of Appalachian Regional Medical Associates.

_____ _____ _____
Sig*nature of Patient* *Date* *Time*

_____ _____ _____
*Signature of Guarantor* *Date* *Time*

_____
*Description of Personal Representative's Authority (attach necessary documentation)*


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