



CURRY

We're All About Caring

General Hospital Health Network

Patient Name Last, First, Middle initial

Mailing address Apt #

City State Zip Code

Phone number

Date of Birth

Social Security #

Employer Name/address/phone

Primary Insurance Holders Name Last,First,Middle initial

Mailing address Apt #

City State Zip Code

Phone number

Date of Birth

Social Security #

Employer Name/address/phone

Sex M F
Marital Status S M W D
Advance Directive? Y N

What is your Ethnicity?

Hispanic or Latino
 Non Hispanic or Latino

What is your Race? (choose one)

White
 American Indian/Alaskan Native
 African American
 Asian
 Native Hawaiian/Other Pacific Islander

Spouse/Parent Name Last, First, Middle initial

Mailing address Apt #

City State Zip Code

Phone number

Date of Birth

Social Security #

Employer Name/address/phone

Emergency Contact Last, First, Middle initial

Relationship to patient

Mailing address Apt #

City State Zip Code

Phone number

Payments, Co-pays, Financial Assistance and Discounts

Payment is expected at the time of your appointment. Special arrangements may be made in advance.

Patients with insurance will pay the co pay on date service is provided.

Insurance will be billed as a courtesy.

Patients without insurance must pay a deposit that will go towards visit.

Patients who pay in full on the same day of service will receive a 20% discount on all goods and services.

Minimum Fees:	New Patients
Minimum	\$185.00
Average	\$283.00

Established Patients	
Minimum	\$99.00
Average	\$144.00

◇ Additional Fees (not included in the minimum fee)
Laboratory Injections Supplies
Xray Medications, etc.

Required Deposits:	Deposit
Deposit	\$150.00

Deposit	\$80.00
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◇ Prices given at the time of service are estimates only.

Financial Assistance Program Eligible patients may apply for additional discounts up to 80%.

Please see receptionist for more information.

Cancellation Fees of \$10 or more may be charged for missed appointments.
Brookings Medical Center requires 24 hour notice for cancelled appointments.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS EFFECTIVE APRIL 14, 2003.

I understand that as part of my healthcare, Curry Health District originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatments
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the option of receiving a copy of the Privacy notification that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided, if I request. I understand that I have the right to object to the use of my health information in the hospital directory. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations and the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance there on. I acknowledge that Curry Health District has informed me of their Privacy Policy.

Signature _____ Date _____

Unable to obtain consent because: True emergency Patient is non-responsive Other:
 Patient has been sedated Patient is confused/disoriented

Consent to release and/or discuss health information with spouse, friend or relative

 (Initials) I authorize Brookings Medical Center to release and/or discuss my medical records/history with the person listed below for the duration of my relationship with Brookings Medical Center or until I revoke this authorization.

 (Initials) I understand that this release may be revoked at any time upon my written request to do so.

Person to release or discuss health information with	Relationship	Date
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I have read and understand the statement above

Signature	Relationship to Patient	Date
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I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collection of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize The Brookings Medical Center to release information necessary to secure the payment of benefits. I consent to treatment as necessary or desirable to the care of the patient first named above, including, but not restricted to, whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray or studies that may be used by the attending provider or nurse, or qualified designate. I also acknowledge full responsibility for payment of such services. I further acknowledge that laboratory and some other tests performed at Brookings Medical Center may be sent to Curry General Hospital, Oregon Medical Laboratories or another testing facility outside of the area. I understand that these services will be billed separately by the testing facility and that I am financially responsible for these services. Oregon Medical Laboratories has agreed to honor a 40% discount for our uninsured patients.

Signature	Relationship to Patient	Date
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