UnityPoint Health

EDT

Date:

PATIENT DEMOGRAPHICS			
Last Name		First Name	
SSN		○ Male ○ Female	DOB
Street Address		Zip	Home Phone
Language	Translator	○ Married ○ Single ○ Divorced ○ Other Marital Status	
Communication Method		Ethnicity	Race
Primary Care Physician			
EMPLOYMENT			
Employer		Employment Status	
PATIENT CONTACTS			
Last Name		First Name	
Street Address		Zip	
Relation to Patient		Home Phone	
GUARANTOR			
Grantor Type ○ Personal/Family ○ 3rd Party ○ Work Comp ○ Other		Who is Responsible ○ Self ○ Father/Mother ○ Employer ○ Other ○ Spouse	
Primary Insurance		Secondary Insurance	
Patient Relation to Subscriber			
Subscriber ID		Member ID	
WORKERS COMP INFORMATION			
Employer		Date of Injury and Body Part	

Patient Label

UPH Downtime Clinic Check In

UnityPoint Clinic

CONSENT TO TREAT: I request and give my consent to medical care and treatment from UnityPoint Clinic providers and healthcare workers. I understand this includes and is not limited to diagnostic procedures, screening procedures, pathology services, and radiology services. I agree that photographs may be taken of me and used for my treatment or identification purposes.

FOR FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: I hereby certify that the information provided by me in order to apply for payment under Titles XVIII and XIX of the Social Security Act or by any third-party payors is correct. I assign payment to UnityPoint Clinic all benefits due to me under-the terms of said policies and programs. I assign payment to the provider(s) rendering medical services and the provider(s) for whom the organization is authorized to bill in connection with its services. I understand that I am required to pay for any health insurance deductibles, coinsurance/copayments or any other charges incurred which are not paid by my insurance or other third-party payers together with all costs of collection, if necessary, including a reasonable attorney's fee if collected by or through an attorney at law.

RECORDS RELEASE FOR CLAIMS PAYMENT: I authorize the release of medical record information or excerpts thereof to any insurance company or third party payer for utilization management audit purposes and/or the purposes of verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization.

CONSENT TO CONTACT: By providing a wireless and/or residential telephone number and/or an email address, I expressly consent to receiving live, autodialed and/or pre-recorded message calls, text messages and/or emails from UnityPoint Clinic and/or its affiliates, agents, contractors or business associates (including but not limited to third party debt collectors) at any phone number or email address, whether cellular, residential or other, associated with my account for any purpose (including but not limited to debt collection or payment) relating to the services provided by UnityPoint Clinic.

My signature below represents I have read and understand the terms and statements above.

This authorization form will remain in effect for 1 year from signature date unless revoked by me in writing, and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this authorization form is to be considered as valid as an original.

Patient Name (please print): _____ Date of Birth: ___ / ___ / ___

Patient Signature: _____ Date: ___ / ___ / ___

Parent/Guardian's Signature: _____

Relationship to Patient: _____

ACKNOWLEDGMENT OF PRIVACY PRACTICES RECEIPT

I have been given a brochure on Notice of Privacy Practices:

Patient or Guardian Signature _____ Date: ___ / ___ / ___

I do not want a brochure on Notice of Privacy Practices:

Patient or Guardian Signature _____ Date: ___ / ___ / ___