DCH SYSTEM
DICKINSON COUNTY HEALTHCARE SYSTEM

Clinic Patient Consent Form

Place Patient Label Here

Patient Demographics

Patient Name _____
(Last – Jr, Sr., III) (First) (Middle Initial)

Maiden Name: _____ Date of Birth: _____ Age: _____

Mailing Address: _____ Gender: _____ Marital Status: _____

City / State / Zip: _____ Social Security Number: _____

Home Telephone: _____ May we leave a phone message? ☐Yes ☐No

Cell Phone: _____May we leave a phone message? ☐ Yes ☐ No

Email Address:_____Pharmacy:_____ Family Doctor:_____

Patient's Employer: _____May we call you at work? ☐ Yes ☐ No Work Phone: _____

Race/Ethnicity: ☐ Asian/Pacific Islander ☐ Black ☐ Caucasian ☐ Hispanic
☐ American Indian ☐ Alaskan Native ☐ Declined

Preferred Language: ☐ English ☐ Other: _____

Emergency Contact

1. Parent, Spouse, Nearest -
Relative or Guardian: _____ Relationship to Patient: _____
Mailing Address: _____ Home Phone: _____
Occupation / Employer: _____ Work Phone: _____

2. Parent, Spouse, Nearest -
Relative or Guardian: _____ Relationship to Patient: _____
Mailing Address: _____ Home Phone: _____
Occupation / Employer: _____ Work Phone: _____

Advance Directives (Living Will)

Does patient have written Advance Directive: ☐ Yes ☐ No
Further information requested by patient: ☐ Yes ☐ No/Declined
Annual offer of Advance Directive:
Date: _____

Is copy on file in clinic chart? ☐ Yes ☐ No
Date Copy Requested From Patient: _____

Authorization to Release Information

I, _____ give Dickinson County Healthcare Systems, permission to speak with the following people regarding my medical and/or financial information. This authorization is valid until such time as I provide DCHS written revocation of it.

_____ _____ ☐ Financial ☐ Medical
Name and Phone Number Relationship to Patient

_____ _____ ☐ Financial ☐ Medical
Name and Phone Number Relationship to Patient

Complete back side

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Patient Rights and Responsibilities

_____ **PATIENT'S RIGHTS AND RESPONSIBILITIES** have been made available to me and **I have read and understand**
Initial these rights and responsibilities.

_____ **I have declined a copy** of the **PATIENT'S RIGHTS AND RESPONSIBILITIES** and am aware that they are available
Initial To me at www.dchs.org or on request in the future.

Photo Consent

_____ I give Dickinson County Hospital Healthcare Systems permission to photograph me during my visit.
Initial

Financial Responsibilities

_____I understand and will abide by the terms within the Financial Responsibilities Policy that has been provided to me.
Initial

Notice Of Privacy Practices

The Notice of Privacy Practices for Dickinson County Healthcare System has been made available to me for my review. I understand that I may request a copy of the notice or obtain a copy from their website at www.dchs.org at any time.

_____ _____
Patient/Representative's Signature **Date**

AGREEMENT FOR EXAMINATION AND/OR TREATMENT

I hereby agree and consent to be examined and treated by my physician. I understand I have the right to participate in decisions involving my health care. In the event I may be harboring an infectious disease such as Hepatitis B or Human Immunodeficiency Virus (HIV) which could endanger the health of individuals accidentally exposed to my blood or body fluids, I do herby voluntarily consent to such routine diagnostic procedures and care provided by Dickinson County Healthcare System as is deemed necessary by my physician (or designee) or by the staff of the Clinic. I further understand that any test results will become part of my medical record, and as such its confidentiality is protected by Federal Law. I understand my medical information including test results will be sent to our Patient Portal to view at my convenience.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dickinson County Healthcare Systems to release information to insurance carriers concerning my or my minor's illness and treatment and/or for collection of monies due the physician who provided the service. I also assign benefits to Dickinson County Healthcare Systems for medical services rendered to myself or my minor. I understand I am responsible for any and all insurance deductibles, coinsurances, and remaining non-covered charges. *I understand that any charges submitted on my behalf are billed according to the physician's written orders under the terms of the provider's relationship to the payer.* **I HAVE READ THIS CONSENT AND I AM FULLY AWARE OF AND AGREE TO THE CONTENTS. THIS FORM IS VALID FOR ONE YEAR FROM THE DATE OF THE MOST RECENT SIGNATURE.**

_____ _____
Patient or Parent/Guardian's Signature **Date**

_____ _____
Witness Signature Date

Please provide photo ID and all insurance cards to the receptionist.