Adair County Health System
we surround you with care

Adair County Medical Clinics

Medical Record #

Patient Information			
Patient Name:	DOB:	Sex: ☐ Male ☐ Female	
Address:	City:	State	ZIP
Home Phone:	Cell Phone:	Work Phone:	
SSN:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		
Advanced Directive: ☐ Yes ☐ No			
Spouse Name:	Spouse DOB:	Spouse SSN:	

Employer Information			
Patient Employer:	Phone:		
Address:	City:	State	ZIP
Spouse Employer:	Phone:		

Emergency Contact		
Name:	Phone:	Relationship:

If the patient is a minor, please complete the following:			
Mother/Guardian Name:	DOB:	SSN:	
Address:	City:	State	ZIP
Home Phone:	Cell Phone:	Work Phone:	
Employer:	Phone:		
Address:	City:	State	ZIP
Father/Guardian Name:	DOB:	SSN:	
Address:	City:	State	ZIP
Home Phone:	Cell Phone:	Work Phone:	
Employer:	Phone:		
Address:	City:	State	ZIP

Notification of Results—Please initial next to following that you authorize:					
	Leave a message on answering machine/voice mail ☐ Home ☐ Work				
	Leave a message with:	Name		Phone:	
		Name		Phone:	
	Send a letter				
	Other (Specify):				
	Appointment reminders to: ☐ My cell phone ☐ voice mail				

Please initial after reading each statement below and then sign the attestation.	
	Consent to Treatment: I hereby give my consent to the healthcare provider in charge of my care to administer any treatment, diagnostic testing, therapy sessions, or any other care deemed necessary or advisable unless otherwise specified by myself or my designee.
	Assignment of Benefits: I hereby assign all benefits and authorize direct payment to Adair County Medical Clinic of all insurance and Medicare benefits payable for my care not to exceed the hospital's regular charges or the payer's allowable benefits. I understand I am fully responsible to pay for charges incurred, but not covered by this agreement. I agree that any credit balance resulting from payment of insurance or other sources to the hospital may be applied to any other account owed to the health system by me.
	Privacy Notice Acknowledgement Adair County Health System's (ACHS) privacy notice provides information about how we may use and disclose protected health information about you and states your rights with respect to your medical information. ACHS has the right to revise these information practices and amend the Notice of Privacy Practices. In the event of a change, you may obtain a revised copy by requesting one from the hospital registration or business office. A revised notice will be posted in the registration office. I acknowledge that I have been offered a copy of the ACHS Notice of Privacy Practices.
	Patient Rights and Responsibilities: I have been advised of my patient rights and responsibilities as a patient.

I hereby attest that I have read and understand the information provided to me above.

Signature **Date**

Witness **Date**