NEWMAN
REGIONAL HEALTH
EXPRESS CARE

PATIENT INFORMATION:

Legal Name: Last:________________ First:________________ Middle:________________

DOB:____________ Sex: M or Fe Mother's Name:____________ Father's Name:____________

SS#:____________ Primary Care Provider:____________ Referring Provider:____________

Phone: Home:____________ Cell:____________ Work:____________

Marital Status:________Language:____________ Race:____________ Ethnicity: ❑ Not Hispanic ❑ Hispanic

Address:____
City State Zip Code

I would like to enroll for the patient portal: Yes ❑ No ❑ Email:________________

(Parents may have access to their child's portal until 12 years of age due to Kansas HIPPA Laws)

Employer:________________________ Unemployed ❑ Retired ❑ Student ❑

Other Names Used: Nickname:____________ Maiden/Previous Last Name:____________

Preferred Pharmacy:____________ Alternate Pharmacy:____________

COMMUNICATION PREFERENCES: ***WRITTEN***: Mail ❑ Portal ❑ ***VERBAL***: Home ❑ Cell ❑ Work ❑

INSURANCE INFORMATION:

Primary Insurance Company:____________ Policy #:____________ Group #:____________

Name of Subscriber:____________ DOB:____________ Marital Status:________ Relationship:____________

Secondary Insurance Company:____________ Policy #:____________ Group #:____________

Name of Subscriber:____________ DOB:____________ Marital Status:________ Relationship:____________

RESPONSIBLE PARTY/BILLING INFORMATION (Parent who is signing this consent is the responsible party)

Responsible party's relationship to patient: ❑ SELF (skip to the next section) ❑ Mother ❑ Father ❑ Other:____________

Legal Name: Last:________________ First:________________ Middle:________________

DOB:____________ SS#:____________ Phone: Home:____________ Cell:____________

Employer:________________________ Phone: Work:____________

PATIENT DISCLOSURE: ❑ If there is no one to list please check the box (Parents have access until 18 years of age)

I, the patient/legal guardian hereby authorize the individuals listed below to receive any or all medical information concerning the medical/physical condition, treatment and test results of the above listed patient.

Name:________________________ Relationship:____________

Name:________________________ Relationship:____________

Name:________________________ Relationship:____________

EMERGENCY CONTACT (Other than parent(s) if a minor): ❑ If there is no one to list please check the box

Name:________________________ Relationship:____________

Phone: Home:____________ Cell:____________ Work:____________

CONSENT FOR TREATMENT:

I consent to the procedures and treatment which may be performed by Newman Regional Health Express Care. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks. I acknowledge that no guarantees have been made as to the results of examinations and treatment.

I certify that I have read and fully understand the Financial Policy for NRHEC given to me at registration. I, as the patient/legal guardian, or as duly authorized agent of the patient, execute the above agreement by signing below, I agree to all the terms and statements listed on this form.

By my signature below, I acknowledge that I have received or have been offered a copy of NRHEC Notice of Privacy Practices. By signing below I am authorizing NRHEC to call the contact numbers listed on this form. I consent to NRHEC staff and/or automated message system to leave a message concerning my private health information on voicemails, text messages, and email if I have provided that information. NRHEC may also leave a message with an individual that answers the phone numbers listed on this page. NRHEC may also send correspondence through the mail to the address listed on this page.

Patient/Legal Guardian Signature:________________________ Date:____________

Print Name if other than Patient Signing:________________________

Relationship to Patient:________________________ Legal Documents on File if necessary: ❑ Yes ❑ No

Staff Initials:____________