NEWMAN
REGIONAL HEALTH
MEDICAL PARTNERS

1301 W. 12th Avenue, Suite 301 • Emporia, KS 66801
(620) 343-2376 • www.newmanrh.org

PATIENT INFORMATION (please provide ID):

Legal Name: Last:_____ First:_____ Middle:_____

DOB:_____ Sex: M or F Mother's Name:_____ Father's Name:_____

SS#:_____ Primary Care Provider:_____

Phone: Home: _____ Cell:_____ Work:_____

Language:_____ Race:_____ Ethnicity: ❑ Not Hispanic ❑ Hispanic

Address:_____
City State Zip Code

INSURANCE INFORMATION (please provide insurance card):

Primary Insurance Company:_____ Policy #:_____ Group #:_____

Name of Subscriber:_____ DOB:_____ Marital Status:_____ Relationship:_____

FINANCIAL RESPONSIBILITY AND INSURANCE ASSIGNMENT: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient he/she hereby, individually obligates himself/herself to pay the account of the hospital in accordance with the regular rates and terms of the hospital and emergency department physicians, and to pay for any non-covered services. Accounts not paid within 30 days of initial billing may be charged interest at a rate not to exceed the maximum permitted by Law. I authorize each physician or other allied health professional to bill and collect for his/her professional services, separate and apart from the hospital's billing and collections. The undersigned understands that Newman Regional Health is not responsible for collecting insurance or other third party payer claims and agrees to pay Newman Regional Health all costs and charges incurred in connection with the patient's hospitalization. I hereby assign to Newman Regional Health any medical benefits arising out of any policy of insurance insuring the patient or any other person liable for the patient's care to be applied to the charges for services rendered.

I Do_____ Do Not_____ authorize release of information for billing to my insurance. I understand that if I fail to pay in full within 30 days, this restriction will be terminated and my insurance will be billed. (Initials)

CONSENT FOR TREATMENT: I consent to the procedures and treatment which may be performed by Newman Regional Health Medical Partners. 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 examination and treatment. I certify that I have read and fully understand the Financial Policy for NRHMP 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 the NRHMP Notice of Privacy Practices. By signing below, I am authorizing NRHMP to call the contact numbers listed on this form. I consent to NRHMP 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. NRHMP may also leave a message with an individual that answers the phone numbers listed on this page. NRHMP 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: _____