Your Hospital's Logo Here

YOUR HOSPITAL STREET ADDRESS CITY, STATE ZIP TEL (202) 555 - 1212

EMERGENCY DEPARTMENT

DATE:	ENCOUNTER #:	Milit. TIME IN:	MODE-ARR:	REG CL:	MED REC #:	LAST ER VISIT:	TRT AREA ASSIGN:	Milit. TIME:

PATIENT

PATIENT NAME:	SOC SEC #:	DATE OF BIRTH:	AGE:	HOME PHONE:	WORK PHONE:
HOME ADDRESS:	SEX:	RACE:	MARIT. ST	RELIGION:	
EMPLOYER:	EMPLOYER'S ADDRESS:	CITY:	STATE:	ZIP:	

GUARANT

GUARANTOR NAME:	PAT REL TO GUAR:	HOME PHONE:	WORK PHONE:
ADDRESS:	CITY:	STATE:	ZIP:
GUARANTOR'S EMPLOYER:	CITY:	STATE:	ZIP:

INSUR

PRIMARY INSURANCE CARRIER:	POLICY NUMBER:	SUBSCRIBER:
SECONDARY INSURANCE CARRIER:	POLICY NUMBER:	SUBSCRIBER:

VISIT

NATURE OF VISIT:	DATE / TIME OF ACCID / ILLNESS:	PLACE OF ACCIDENT:	WORKER'S COMP:	ATTENDING / REFERRING PHYSICIAN:
EMERGENCY NOTIFICATION:	PHONE:	COMPLAINT:		

CHART Received By:

NAME

DISPOSITION	ADMITTING SERVICE:	Milit. TIME CALLED:	☐ TRANSFER TO:	DISCHARGE Milit. TIME:	☐ DECEASED ☐ POLICE SIG:
☐ ADMIT ☐ ATTACHED ☐ UNATTACHED ☐ TEACHING ☐ NONTEACHING	Attending Physician:	ROOM:		DISCHARGE DATE:	☐ PRIEST
	☐ RESIDENT: ☐ MED. ASSOC:		☐ DISCHARGE	CONDITION ON DISCHARGE:	PATIENT CLASSIFICATION: ☐ AMA
	☐ 2 SOUTH ☐ ICU ☐ 6 SOUTH ☐ REG FLOOR				

TIME ORDERED	PHYSICIAN'S ORDERS	MD SIGNATURE	TIME SENT	INIT

HEALTH INFORMATION MANAGEMENT COPY

RELEASE OF HOSPITAL RECORDS

The Hospital records concerning the patient are the property of YOUR HOSPITAL and are maintained for the benefit of the patient, the medical staff, the hospital, and the patient's insurance carrier. I hereby release YOUR HOSPITAL to release these records to the patient's personal physician, and to any other individual and private or government agency responsible for payment for the patient's care and treatment.

DEPARTURE AGAINST MEDICAL ADVICE

This is to certify I _____ a patient in YOUR HOSPITAL, am leaving against the advice of the attending physician and hospital authorities. I also acknowledge that I have been informed of the risk involved and hereby release the attending physician and hospital from all responsibility for any ill effects which may result.

SIGNED _____ WITNESS _____ DATE _____

CONSENT FOR BLOOD TEST(S)

If a health care worker is exposed significantly to my blood or body fluids, I consent to tests of my blood for hepatitis and antibodies to the virus that causes AIDS (HIV). This testing is done at no cost to me, and I will be notified if these test results are positive.

CONSENT FOR TREATMENT

Permission is hereby granted to the authorities of the hospital for such procedures as they deem advisable for this patient.

PATIENT SIGNATURE _____ WITNESS SIGNATURE _____

DATE _____ WITNESS (PRINT NAME) _____

RELATIONSHIP TO PATIENT (if Patient unable to sign) _____

DATE _____

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PATIENT

PATIENT NAME:	SOC SEC #:	DATE OF BIRTH:	AGE:	HOME PHONE:	WORK PHONE:
HOME ADDRESS:			SEX:	RACE:	MARIT. ST / RELIGION:
EMPLOYER:	EMPLOYER'S ADDRESS:		CITY:	STATE:	ZIP:

GUARANT

GUARANTOR NAME:	PAT REL TO GUAR:	HOME PHONE:	WORK PHONE:
ADDRESS:		CITY:	STATE: ZIP:
GUARANTOR'S EMPLOYER:		CITY:	STATE: ZIP:

INSUR

PRIMARY INSURANCE CARRIER:	POLICY NUMBER:	SUBSCRIBER:
SECONDARY INSURANCE CARRIER:	POLICY NUMBER:	SUBSCRIBER:

VISIT

NATURE OF VISIT:	DATE / TIME OF ACCID / ILLNESS:	PLACE OF ACCIDENT:	WORKER'S COMP:	ATTENDING / REFERRING PHYSICIAN:
EMERGENCY NOTIFICATION:	PHONE:	COMPLAINT:		

CHART Received By: NAME

DISPOSITION	ADMITTING SERVICE:	Milit. TIME CALLED:	☐ TRANSFER TO:	DISCHARGE Milit. TIME:	☐ DECEASED ☐ POLICE
☐ ADMIT ☐ ATTACHED ☐ UNATTACHED ☐ TEACHING ☐ NONTEACHING	Attending Physician: ☐ RESIDENT: ☐ MED. ASSOC: ☐ 2 SOUTH ☐ ICU ☐ 6 SOUTH ☐ REG FLOOR	ROOM:	☐ DISCHARGE	DISCHARGE DATE: CONDITION ON DISCHARGE:	SIG: ☐ PRIEST PATIENT CLASSIFICATION: ☐ AMA

TIME ORDERED	PHYSICIAN'S ORDERS	MD SIGNATURE	TIME SENT	INIT

E.D. ADMISSIONS COPY

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EMERGENCY DEPARTMENT

DATE:	ENCOUNTER #:	Milit. TIME IN:	MODE-ARR:	REG CL:	MED REC #:	LAST ER VISIT:	TRT AREA ASSIGN:	Milit. TIME:

PATIENT

PATIENT NAME:	SOC SEC #:	DATE OF BIRTH:	AGE:	HOME PHONE:	WORK PHONE:
HOME ADDRESS:			SEX:	RACE:	MARIT. ST / RELIGION:
EMPLOYER:	EMPLOYER'S ADDRESS:		CITY:	STATE:	ZIP:

GUARANT

GUARANTOR NAME:	PAT REL TO GUAR:	HOME PHONE:	WORK PHONE:
ADDRESS:		CITY:	STATE: ZIP:
GUARANTOR'S EMPLOYER:		CITY:	STATE: ZIP:

INSUR

PRIMARY INSURANCE CARRIER:	POLICY NUMBER:	SUBSCRIBER:
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VISIT

NATURE OF VISIT:	DATE / TIME OF ACCID / ILLNESS:	PLACE OF ACCIDENT:	WORKER'S COMP:	ATTENDING / REFERRING PHYSICIAN:
EMERGENCY NOTIFICATION:	PHONE:	COMPLAINT:		

CHART Received By: NAME

DISPOSITION
- ☐ ADMIT
- ☐ ATTACHED
- ☐ UNATTACHED
- ☐ TEACHING
- ☐ NONTEACHING

ADMITTING SERVICE:

Attending Physician:

- ☐ RESIDENT:
- ☐ MED. ASSOC:
- ☐ 2 SOUTH ☐ ICU
- ☐ 6 SOUTH ☐ REG FLOOR

Milit. TIME CALLED:

ROOM:

☐ TRANSFER TO:

DISCHARGE Milit. TIME:

DISCHARGE DATE:

☐ DISCHARGE

CONDITION ON DISCHARGE:

☐ DECEASED ☐ POLICE

SIG:

☐ PRIEST

PATIENT CLASSIFICATION:

☐ AMA

GUARANTEE OF ACCOUNT: (Financial Responsibility) I / we agree to pay the established rate of YOUR HOSPITAL and it's agents, including but not limited to physicians fees, for all services rendered for the patient as named above. It is understood that my / our obligation will include any balance not covered by insurance. It is further understood that if my / our insurance does not pay within (60) days of treatment or discharge, I / we will become responsible for payment in full unless limited by contractual agreement or government regulation.

RELEASE OF INFORMATION: I hereby authorize YOUR HOSPITAL and it's agents, including but not limited to all physicians involved with my care, to release information from my medical record to include treatment for psychological or psychiatric impairment, substance abuse, alcoholism, sickle cell anemia, acquired immunodeficiency syndrome (AIDS), test for human immunodeficiency virus (HIV), sexually transmitted diseases, sexual assault, criminal cases and photographs, unless otherwise specified herein, as may be required to any person, corporation or agency legally responsible for processing and / or paying all or part of the hospital's charges and / or professional fees; and, to any entity which was contracted for an insurer to conduct utilization review of performance review.

ASSIGNMENT OF BENEFITS: In the event the undersigned is entitled to benefits of any type arising out of any policy or contract of insurance, such benefits are hereby irrevocably assigned to the hospital and its agents, including but not limited to all physicians involved with my care. Such insurance includes, but is not limited to any private commercial insurance, other managed care companies and any public funding, including Medicaid / Medicare and Workman's Compensation. Also, where applicable, the undersigned assigns the benefits payable for physicians services to the physician or organization furnishing the services or authorizes such physician or organization to submit a claim to Medicare, or other insurance carrier, for payment directly to the physician or organization.

SERVICE RELEASE: The above referenced insurance company requires that I receive services (lab, x-ray, ekg, etc.) at a participating facility in order to receive full coverage for this service. However, I elect to receive the service at YOUR HOSPITAL, a non-participating facility, and agree to be financially responsible for any charges not covered by my insurance.

Patient or parent, if minor _____ Date _____ Witness _____ Date _____

Insurance subscriber, if different than patient (relationship to patient) _____ Date _____

PATIENT FINANCIAL SERVICES COPY