VIDANT HEALTH™

PATIENT REGISTRATION FORM

Date: _____ (To be completed by staff - MR #_____, Chart #_____)

Last Name: _____First Name: _____ Middle/Maiden_____

Preferred Name:_____ Date of Birth: ____ / ____ / _____ Age: _____ Race:_____

Sex: Male / Female SSN: _____ - _____ - _____ Marital Status: ____Single ____Married ____Divorced ____Widowed

Mailing Address: _____City/State/Zip: _____

Physical Address: _____City/State/Zip: _____

Home Phone #_____ Cell #_____ Work #_____

Ethnic Group: Non-Hispanic / Hispanic / Unknown Preferred/Primary Language:_____

Need Interpreter: Yes / No E-mail Address: _____

Employment Status: Full Time / Part Time / Retired / Self Emp / Disabled / Active Military / Student / Minor / Not Employed

Employer: _____ Occupation:_____

Emergency Contact Name: _____Relationship:_____ Phone#: _____

Primary Care Provider (PCP):_____ PCP Phone #:_____

Who referred you? _____

Do you have an Advance Directive or Living Will: Yes / No If yes, please provide us with a copy.

Do you have a Financial and/or Medical Power of Attorney: Yes / No If yes, please provide us with a copy.

INSURANCE INFORMATION – Please provide your insurance card/cards

Insurance Company Name: _____

Subscriber's Name: _____ Subscriber's Date of Birth _____

Policy #:_____ Group #:_____ Relationship to Patient:_____

Secondary Insurance Company Name: _____

Subscriber's Name:_____ Subscriber's Date of Birth:_____

Policy #_____ Group #_____ Relationship to Patient:_____

PARENT/LEGAL GUARDIAN/SPOUSAL INFORMATION

Name: _____

Relationship to Patient: _____

Date of Birth:_____SSN_____

Address: _____

City/State/Zip: _____

Home #: _____ Cell#:_____

Employer Name: _____

Work #:_____

OTHER INFORMATION

Pharmacy Name: _____

Pharmacy Address:_____

_____

Pharmacy Phone #:_____

Religion:_____

Primary Caregiver:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize payment of all medical benefits which are payable to me under the terms of my insurance policy to be paid directly to the above named physician for services rendered.

Signature of Patient/Guardian Date

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VIDANT HEALTH™ MRN_____

Patient Name:	**Date of Birth:**

Symptoms	***Circle one***		***When did it start?***		
Fever	NO	YES			
Cough	NO	YES			
Shortness of breath or difficulty breathing	NO	YES			
Fatigue	NO	YES			
Muscle or body aches	NO	YES			
Headache	NO	YES			
New loss of taste or smell	NO	YES			
Sore Throat	NO	YES			
Congestion or runny nose	NO	YES			
Nausea or vomiting	NO	YES			
Diarrhea	NO	YES			

CLINICAL STAFF ONLY:

Resources Provided:	Signature of Staff Providing/Educating:
Local Primary Care Providers	
Local Social Determinants of Health information	
COVID-19 Education Packet • The Key Facts • Stop the Spread • Wash Your Hands • Tips for Keeping Masks Clean • What to do if You Feel Sick **English** **Spanish**	

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VIDANT HEALTH™

MRN_____

HIPAA AUTHORIZATION FOR RELEASE OF CONFIDENTIAL COVID-19 TEST RESULT/STATUS

1. **My name** (name of person whose COVID-19 test result ("Test") will be released: _____.
I UNDERSTAND THAT IF I AM AN EMPLOYEE OF VIDANT HEALTH OR ITS AFFILIATES/SUBSIDIARIES, I AM NOT REQUIRED TO EXECUTE THIS AUTHORIZATION AS A CONDITION OF EMPLOYMENT.

2. Name of organization that I am authorizing to release COVID-19 test results (this is the entity which performed the COVID-19 test): Vidant Health affiliates, to include Pitt County Memorial Hospital, Incorporated d/b/a Vidant Medical Center, East Carolina Health-Bertie d/b/a Vidant Bertie Hospital, East Carolina Health-Chowan, Inc. d/b/a Vidant Chowan Hospital, The Outer Banks Hospital, Inc., East Carolina Health-Heritage, Inc. d/b/a Vidant Edgecombe Hospital, East Carolina Health, d/b/a Vidant Roanoke-Chowan Hospital, East Carolina Health-Beaufort, Inc., d/b/a Vidant Beaufort Hospital, Halifax Regional Medical Center, Inc. d/b/a Vidant North Hospital, East Carolina Health, d/b/a Vidant Community Hospitals, and/or Vidant Medical Group, LLC

3. Person(s) or organization(s) that I am authorizing to receive these COVID-19 test results:

A. **VIDANT HEALTH, ITS AFFILIATES, SUBSIDIARIES AND ITS VARIOUS BUSINESSES AND DEPARTMENTS**
B. **MY EMPLOYER (NAME:_____) *UNLESS I OPT-OUT***
C. **OTHER ENTITY (NAME & ADDRESS/FAX #):** _____

4. This authorization will expire on the following date or when the following event takes place:

ONE (1) YEAR FOLLOWING THE DATE OF EXECUTION

5. I hereby consent to and authorize (i) the disclosure of my completed Test results to the lab(s) in order to permit the lab(s) to analyze and interpret my Test, and to the entity or entities listed above in Section 3, (ii) the disclosure of my Test results in any manner permitted by federal or state privacy and security laws, and (iii) to the county, state, or to any other governmental entity as may be required by law. My Test results may also be shared with my employer unless I opt out as indicated below in Section 10.

6. I understand that, unless otherwise stated below, I am not required to sign this form and signing the form is not a condition of employment, receiving treatment, payment, enrollment, or eligibility for benefits of any kind.

7. I can change my mind at any time and revoke this authorization in writing. The written revocation must be given to the person(s) that I authorized to release the test results. I understand that if I do revoke this authorization, it will not affect the uses and disclosures of test results and/or COVID-19 diagnosis that have already occurred based on my authorization.

8. I understand that information used or disclosed based on this authorization may possibly be re-disclosed by the recipient and/or no longer be protected by privacy laws or standards.

9. My questions about this form have been answered to my satisfaction. I also understand that if I sign this authorization, I will be provided a copy of this authorization.

10. I UNDERSTAND THAT THE TEST RESULT **WILL BE SHARED WITH MY EMPLOYER** UNLESS I ELECT TO OPT-OUT. BY INITIALING HERE _____ I AM OPTING OUT AND MY TEST RESULT MAY **NOT** BE SHARED WITH MY EMPLOYER. I UNDERSTAND, HOWEVER, THAT IF I AM AN EMPLOYEE OF VIDANT HEALTH OR ITS AFFILIATES/SUBSIDIARIES, THEN MY TEST RESULTS MAY BE SHARED WITH MY EMPLOYER FOR THE EXCLUSIVE AND LIMITED PURPOSES OF PROVIDING A REASONABLE ACCOMMODATION UNDER THE AMERICANS WITH DISABILITIES ACT, PREVENTING A DIRECT THREAT TO SAFETY IN THE WORKPLACE AND/OR AS MAY OTHERWISE BE PERMITTED OR REQUIRED BY APPLICABLE LAW.

By signing below I authorize the person(s) and organization(s) that I have designated above to receive my COVID-19 tests results and/or status and that the test results may be used as specified herein.

Signature: _____

Date (mm-dd-yy): _____ Time: _____

Printed Name: _____

Relationship to Patient: _____
(Parent, Guardian, Legally Authorized Representative) If you are an authorized representative (other than a paretn of a minor child), you will need to proved documetnation of your athority to act dor the member (e.g. Health Care Powere of Attorney).

VIDANT HEALTH™ MRN_____

CONSENT FOR CORONAVIRUS 2019 (COVID-19) TESTING
PATIENT AUTHORIZATION/ACKNOWLEDGEMENT OF BENEFITS RELEASE

"I" "me" "my" or "myself" refers to the patient named below. "Vidant Health" refers to particular Vidant Health affiliated hospital, clinic, Health or other service to which I have been accepted as a patient. "Medical Staff Members" refers to all physicians and advanced practice professionals who provide medical treatment at Vidant Health.

The following are the conditions for services provided by Vidant Health for the patient whose name appears at the bottom of this page.

CONSENT FOR COVID-19 TEST

I voluntarily consent to the administration of a COVID-19 test provided by Vidant Health and its associated Medical Staff Members and other personnel for myself. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of the test. I understand that, as with any medical test, there is the potential for false positive or false negative test results can occur.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Vidant Health and its associated Medical Staff Members to release the test results required in the processing of applications or submission of information for financial coverage and further medical treatment. I also agree to the release of test result information about me to government federal or state regulatory agencies as required by law.

ASSIGNMENT OF INSURANCE BENEFITS

I assign my rights in any insurance benefits or other funding to the physician and Vidant Health.
For Medicare beneficiaries: I have provided all necessary information for proper assignment of Medicare benefits.

WORKER'S COMPENSATION PATIENT RECORDS RELEASE AND AUTHORIZATION FORM

I understand that North Carolina Worker's Compensation law provides that written information which pertains directly to a workers' compensation claim must be provided by a healthcare facility/physician to the insurance carrier, the employer, the employee, their attorneys, or the applicable State Workers' Compensation Commission pursuant to NCGS § 97-27.

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. I understand that I should read it carefully. The notice describes how my health information may be used or disclosed. I am aware that the Notice may be changed at any time.
The Notice of Privacy Practices may be accessed at www.vidanthealth.com.

_____ _____
Name of Patient Signature of Patient (Relationship to Patient)
(Parent, Guardian or Legally Authorized Representative

_____ _____
Date Time

_____
Clinic Witness


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