PATIENT ENROLLMENT AND CONSENT FORM

NAME: _____ **DOB**: _____
FIRST *MIDDLE INITIAL* *LAST* *MM / DD / YY*

MARITAL STATUS: _____ **GENDER**: ☐ Male ☐ Female ☐ Transgender

HOME MAILING ADDRESS: _____
STREET *APT/BOX #*

_____
CITY *STATE* *COUNTY* *COUNTRY* *ZIP CODE*

OTHER ADDRESS: _____
STREET *APT/BOX #*

_____
CITY *STATE* *COUNTY* *COUNTRY* *ZIP CODE*

PRIMARY PHONE: _____ ☐ Home ☐ Cell ☐ Work ☐ Other:_____

ALTERNATE PHONE: _____ ☐ Home ☐ Cell ☐ Work ☐ Other: _____

EMAIL: _____ **PREFERRED METHOD OF CONTACT:** ☐ Cell ☐ Home ☐ Email

PRIMARY LANGUAGE: _____

RACE: ☐ White/Caucasian ☐ Asian ☐ American Indian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Other: _____ ☐ Patient Declined

ETHNICITY: ☐ Hispanic ☐ Arab ☐ Other: _____ ☐ Patient Declined ☐ Non Arabic/Hispanic

DO YOU HAVE INSURANCE? ☐ Yes ☐ No **NAME OF INSURANCE:** _____

ID/POLICY #: _____ GROUP #: _____ **CO-PAY**: _____

RELATIONSHIP TO SUBSCRIBER: ☐ Self ☐ Spouse ☐ Parent/Child ☐ Other: _____

SUBSCRIBER: _____ **SUBSCRIBER'S BIRTHDATE**: _____
MM / DD / YY

SUBSCRIBER'S ADDRESS: _____
STREET *APT/BOX #*

_____
CITY *STATE* *COUNTY* *COUNTRY* *ZIP CODE*

IN CASE OF EMERGENCY PLEASE NOTIFY: _____
FIRST NAME *LAST NAME* *RELATIONSHIP*

PHONE NUMBER: _____ ☐ Home ☐ Cell ☐ Work ☐ Other:_____

I authorize and consent to medical, diagnostic, therapeutic, and other procedures and treatment by the physicians, physician assistants, nurse practitioners and other staff at Nursing Practice Corporation, a Michigan non-profit corporation doing business as Campus Health Center ("Center"). I understand the risks of the medical treatment and procedures, and that the practice of medicine is not an exact science. No guarantees or promises have been made concerning the outcome of any procedures or treatment. I understand that I have the right to make decisions concerning my health care, including my right to refuse medical and surgical procedures. I understand that if any agent or employee of the Center AT ANY TIME sustains a percutaneous (through the skin), mucous membrane (through the mouth or eye), or open wound or other significant exposure to my blood or other bodily fluids, I may be tested for HIV (the virus that causes AIDS), Hepatitis B, Hepatitis C, and/or Syphilis, and I consent to such tests. Any changes in this consent must be initialed by the patient and a member of the Center staff and may result in the reduction of services.

SIGNATURE: _____ **DATE**: _____
(Parent or guardian must sign if patient is under 18, incompetent, disoriented or mentally unstable) *MM / DD / YY*

I have received and reviewed the Center's *Notice of Privacy Practices* that contains more detailed information about how, why and when the Center may use and disclose Protected Health Information ("PHI"), as defined by HIPAA. I acknowledge that the Center may, from time to time, change its privacy practices and agree that Center may use and disclose my PHI in accordance with its *Notice of Privacy Practices*.

SIGNATURE: _____ **DATE**: _____
(Parent or guardian must sign if patient is under 18, incompetent, disoriented or mentally unstable) *MM / DD / YY*

I certify that all information provided by me on this form is true and correct, that I fully understand the consents and authorizations given above, that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily, and that I am the Patient listed in this document or I am duly authorized by the Patient listed in this document to provide the consents and authorizations described herein and to sign this document. I hereby assign to the Center all rights to insurance payment for professional services provided by it. This assignment will remain in effect until it is revoked in writing by Patient or a person authorized to revoke it on Patient's behalf. A photocopy of this assignment is to be considered as valid as the original. I agree to pay to the Center for charges resulting from services rendered that are not covered by insurance or other third party payment. I agree all bills are due in full at the time of service. Should I fail to honor these obligations, I agree to pay any collection costs and attorney fees resulting from collection of my accounts.

SIGNATURE: _____ **DATE**: _____
(Parent or guardian must sign if patient is under 18, incompetent, disoriented or mentally unstable) *MM / DD / YY*