



Uninsured

Revised 4/5/2018

Ebenezer Medical Outreach, Inc.

Welcome to Ebenezer Medical Outreach, Inc. (EMO). We appreciate your choosing us for your health care needs, and we are committed to doing our best for you. Our goal is to provide you with high-quality, affordable health care.

If you are uninsured, there may be financial assistance options available to you through the Marshall Health Charity Care Policy. Please contact the Marshall Health financial counselor at 304-691-1029. However, you will need to provide EMO the following for everyone living in your household:

- Most recent income tax return (1040 Form) and pay stubs for 1 month
- Social Security Award letter dated for the current year
- Unemployment statement
- Food stamp statement
- Child Support letter
- Pension award letter
- If homeless or are in a shelter, you must have a letter on letterhead from shelter or social worker stating you stay there or are deemed homeless.
- If you receive public housing a statement from housing stating the amount they pay.
- If you receive money from someone for services provided (housework, grass cutting, etc.) you will need a notarized letter from the person you are working for with the amount.
- **If you live with someone bring in the income of the person you are living with (see above list and bring in all that applies).**
- Everyone must have Denial letter from DHHR.
- **ALL INFORMATION MUST BE CURRENT. Also please bring in:**
- **Proof of income (listed above)**
- **Picture ID**
- **A piece of mail with your home address (not P. O. Box)**

We will accept Medicaid, Medicare and Private Insurance. If you have an insurance card it will need to be presented at the time of service.

Thank you for choosing us for your medical care.

PATIENT'S AGREEMENT

Pease Read Carefully

I consent to care and treatment

I consent to examination, treatment and testing as advised by the physicians and other providers of Ebenezer Medical Outreach, Inc.(EMOI). I give permission for health care professionals in training to observe and participate in my care and treatment under the supervision of licensed health care providers. In addition, I consent to the use or disclosure of my protected health information by EMOI to diagnose and treat me, to obtain payment for my bills and to conduct its health care operations and business.

I acknowledge that I have received or was offered a copy of EMOI Notice of Privacy Practices

which tells how my health information may be used and shared. I understand that EMOI reserves the right to revise the notice at any time, and that I can always get the current copy by asking for it.

All patients accepting care at Ebenezer must:

- Maintain an accurate address, contact telephone number, current proof of income and notification of any receipt of medical insurance, which includes Medicaid, Medicare, VA benefits or private insurance.
- Show up at the clinic on time or cancel by telephone at least one workday (24 hours) prior to the scheduled appointment time. In those situations when special tests or follow up is required for the clinic, failure to obtain required tests/follow up will result in the clinic appointment being rescheduled at a later date.
- The patient must follow the instructions given for the recommended follow up for care such as: keeping additional appointments, obtaining special tests or lab work.

I agree that payments can be made to University Physicians and Surgeons, Inc.

EMOI has contracted with University Physicians and Surgeons, Inc, (UP&S) DBA Marshall Health. I allow University Physicians and Surgeons, Inc, (UP&S) to directly bill and collect payment from Medicaid. I assign my right to receive payment of any insurance to UP&S.

I agree to have EMOI complete any enrollment process, which includes providing financial information, for available patient assistance programs sponsored by pharmaceutical companies to secure my prescribed medication.

If you have any questions about this document, please ask someone at the front desk for assistance.

I have read this form and I fully understand what I am agreeing to. *(The patient or another responsible party on behalf of the patient must sign this Agreement. Upon signing, the responsible party assumes all liability for the consents, authorizations and financial responsibility discussed above.)*

Date	Signature of Patient or Legal Representative	Qualifier
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STATEMENT OF PATIENT'S LEGAL REPRESENTATIVE OR AGENT

I give the consents and authorizations made above on behalf of the patient and I have the authority to do so. The patient did not sign because he or she is (check one):

_____ Mentally or physically unable to understand or sign

_____ Other (describe): _____

I am authorized to sign for the patient because: *(for example, having medical power or attorney)* _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Employer Name _____

Employer Address _____
STREET

CITY STATE ZIP

Spouse's Name/Other Parent is under 18 _____

Employer Name _____ Work Phone _____

In case of an emergency, notify (friend or relative not in your home):

Name _____ Phone _____

Relationship to Patient _____

INSURANCE INFORMATION

Primary Medical Insurance _____ Phone _____

Policy Holder Name _____ Date of Birth _____

Address _____
STREET

CITY STATE ZIP

ID Number _____ Group Number _____
Plan Number _____ Effective Date _____ Expiration Date _____

Secondary Medical Insurance _____ Phone _____

Policy Holder Name _____ Date of Birth _____

Address _____
STREET

CITY STATE ZIP

ID Number _____ Group Number _____
Plan Number _____ Effective Date _____ Expiration Date _____

Other Medical Insurance (Worker's Comp., Medicare Supplement, Etc.)

Medical Insurance _____ Phone _____

Policy Holder Name _____ Date of Birth _____

Address _____
STREET

CITY STATE ZIP

ID Number _____ Group Number _____
Plan Number _____ Effective Date _____ Expiration Date _____

