EBENEZER MEDICAL OUTREACH

We do not provide:

NARCOTICS OR ANY CONTROLLED MEDICATION

(Including anti-anxiety medication such as Xanax, Valium, Ativan or Klonopin)

Ebenezer Medical Outreach, Inc. • 1448 Tenth Avenue, Suite 100 • Huntington, WV 25701
(304) 529-0753 • Fax (304) 529-0591

Authorization for Release of Medical Records

_____ (Print Patients Full Name)

_____ Birth Date (mo/day/yr)

_____ (Street Address)

_____ (Social Security Number)

_____ (City, State, Zip)

_____ (Phone – Home)

At the request of the individual, I _____, do hereby authorize _____ (Name of Doctor that you have seen)

Dates of _____

____	Discharge Summary	____	Pathology Reports	____	Emergency Reports
____	History and Physical	____	Laboratory Reports	__X_	All Records
____	Progress Notes	____	Radiology Reports	____	Other _____
____	Operative Reports	____	ECG/EEG/Cardiac Cath		

____ I do ____ I do **NOT** authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

I give my permission for any confidential information to be released verbally to:

_____ (Name)

_____ (Relationship)

Information Release to: EBENEZER MEDICAL OUTREACH INCORPORATED
1448 10TH AVE. SUITE 100
HUNTINGTON, WV. 25701
Phone: 304-529-0753
Fax: 304-529-0591

Purpose of Disclosure:

____	Referral to Specialist	____	Insurance	____	Workers Comp
____	Change of Physician	____	Legal Investigation	____	Disability Determination
____	Personal	__x_	Continuity of Care	____	Service Management
____	Other _____				

I hereby authorize disclosure of the health information for the above needed patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or the class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign authorization.

_____ Signature of individual or guardian or personal representative of patients' estate

_____ Date

NEW PATIENT HISTORY FORM

Name:_____ Date:_____ **Date of Birth**_____

Marital Status: S M W D Allergies:_____

Recent Medical problems:_____

_____

Review of Body Systems: (Check all that apply to you)

	Now:	In the Past:		Now:	In the Past:
Asthma or Emphysema	_____	_____	Kidney Stones	_____	_____
Shortness of Breath	_____	_____	Blood in Urine	_____	_____
Coughing up blood	_____	_____	STD	_____	_____
Lung Disease	_____	_____	Sexual Problems	_____	_____
Seasonal Allergies	_____	_____	Urinary Problems	_____	_____
Chest Pain	_____	_____	Heartburn/ GERD	_____	_____
Heart Disease	_____	_____	Gallbladder Disease	_____	_____
High Blood Pressure	_____	_____	Ulcers	_____	_____
Thyroid Disorder	_____	_____	Colitis	_____	_____
Nervous Disorder	_____	_____	Constipation/ Diarrhea	_____	_____
Depression	_____	_____	Hepatitis	_____	_____
Epilepsy/ Seizures	_____	_____	Rectal Bleeding	_____	_____
Diabetes	_____	_____	Change in Bowel Habits	_____	_____
Cancer	_____	_____	Recent weight change	_____	_____
Dental Problems	_____	_____	Problems sleeping	_____	_____

Other_____

Current Medications and Doses:_____

_____

Past History: Illnesses:_____

Surgeries (when)_____

Other hospitalizations (when)_____

Last Pap Test_____ Mammogram_____ Last Rectal Exam_____ Last Dr. visit_____

Personal History: (Circle all that apply) Do you…..

Regularly exercise? Now Past Never Use Illegal Drugs? Now Past Never

Wear Seatbelt? Now Past Never Use Alcohol? Now Frequently Now some Past Never

Use tobacco products? Now (cigarettes- how many?_____ other?_____ Past Never

Do you do self Breast exam?_____ Self Testicular Exam?_____

Family History

Mother: Alive Deceased
Cause of Death: _____

Father: Alive Deceased
Cause of Death: _____

Brothers and Sisters: Number Living: _____
Number Deceased: _____

Cause of Death: _____

Medical Conditions: _____

Family History: Mother Grandmother Grandfather Father Grandmother Grandfather Bro/Sister

Cancer	_____	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____	_____	_____

Other Medical conditions in family_____

_____

Insured

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.

Thank you for choosing us for your medical care.

PATIENT INFORMATION

Patient Name _____
LAST FIRST MIDDLE MAIDEN

Date of Birth _____ Sex: □ M □ F Marital Status: □ Single □ Married □ Divorced □ Widowed

Social Security Number _____ Email Address _____

Preferred Language:

□ Arabic	□ English	□ Hindi	□ Spanish
□ Chinese	□ German	□ Russian	□ Other: _____

Race:

□ African American	□ Asian	□ Hispanic/Latino	□ Pacific Islander
□ Alaska Native	□ Caucasian/White	□ Native American	□ Declined

Ethnicity:

□ Hispanic/Latino □ Non-Hispanic/Latino □ Declined Are you a US Citizen? □ Yes or □ No

Patient Address _____
STREET COUNTY

_____
CITY STATE ZIP

Driver's License Number _____
STATE

Home Phone _____ Work Phone _____ Mobile Phone _____

Employer Name _____

Employer Address _____
STREET

_____
CITY STATE ZIP

Primary Care Provider _____

If under 18, who is parent or legal guardian?

Guardian Name _____ Date of Birth _____

Responsible Party (Person who will be responsible for any amount not covered by insurance)

_____

Relationship to Patient _____

Social Security Number _____ Date of Birth _____

Address _____
STREET

_____
CITY STATE ZIP

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 _____

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. I also agree if needed, for Astra Zeneca to review necessary records for audit purposes.

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

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)* _____