



Uninsured

Revised 2/20/19

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 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 _____

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

Use tobacco products? Now (cigarettes) How many? ____ Others? ____ Past ____ Never ____

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

Family History

Mother: Alive Deceased Father: Alive Deceased
Cause of Death: _____ Cause of Death: _____

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

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 _____





Ebenezer Medical Outreach, Inc.

1448 10th Avenue, Huntington, WV 25701
Phone: 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 _____

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

EBENEZER MEDICAL OUTREACH, INC.

We do not provide:

**NARCOTICS OR ANY
CONTROLLED
MEDICATION**

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

PATIENT'S AGREEMENT

Please 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 (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)* _____