NANTICOKE
PHYSICIAN NETWORK
Always Caring. Always Here.

Patient Emergency Contact and Confidentiality Information
Statement of Receipt of Privacy Practices and Consent for Treatment

Patient Name: _____ Date of Birth: _____

Please list the family members or other persons whom we may inform about your medical condition **or** in case of an emergency:

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

Please print the name and address where we should send correspondence if other than your home:

_____

Preferred method of contact regarding health information, i.e. appointments, test results. ☐ Phone: _____ ☐ Portal

Do we have your consent to leave confidential messages on your answering machine or voice mail? ☐ Yes ☐ No

Patient Health Information and Confidentiality
I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. This authorization shall be in effect until I instruct otherwise by completing a new form with any changes. I understand that I have the right to revoke this authorization at any time by completing a new form detailing changes. I understand that if authorization is revoked, it will not apply to information already released in response to this authorization.

Statement of Receipt of Notice of Privacy Practices
I, the undersigned, hereby acknowledge receipt of a written copy of the ***NOTICE OF PRIVACY PRACTICES of the NANTICOKE PHYSICIAN NETWORK*** on the date appearing next to my signature.

Consent for Treatment and Financial Agreement:
I consent to the use of my protected health information for the purposes of treatment, payment, and operations. I hereby request treatment to be performed by providers of Nanticoke Physician Network and/or their assistants. Such treatment to include: x-ray, injections, and other such procedures as they deem necessary. I accept full responsibility for any charges incurred for services rendered to me.

If services are rendered in Immediate Care locations and you do not have insurance, a fee of $125 is due prior to receiving service. It is my understanding that Nanticoke Immediate Care may send lab specimens to an outside laboratory or x-rays to an outside radiologist for interpretation. I give permission for those outside entities to bill for their services. I understand that I may incur additional charges as a result of those services provided.

_____ _____
Date Signature of Patient or Guardian

_____
Printed Name of Patient or Guardian

Verbal Consent:
Verbal consent to above received from Parent or Guardian:

Parent or Guardian Name _____

Patient Representative _____ Relationship_____
The patient's representative ☐ DOES ☐ DOES NOT assume financial responsibility.

By Employee: _____ Date & Time: _____