



The Washington Electronic Health Record System

PATIENT REGISTRATION

CONSENT FOR TREATMENT

I consent to the treatment necessary for the above named patient. I authorize the release and/or fax of all my medical records to the referring and family physicians and to my Worker Compensation Carrier Company, if applicable. If lab or x-ray is needed, I authorize access to my medical records through the WeCare electronic medical record. I hereby authorize Washington Hospital Healthcare System (Washington Hospital, Washington Township Medical Foundation, Washington On Wheels, Washington Urgent Care, Washington Outpatient Rehabilitation Center, and Washington Radiation Oncology Center) to obtain my prescription/medication history electronically from multiple sources including pharmacies and physicians outside the practice as medically necessary for my treatment. I authorize WHHS to obtain my prescription/medication history as often as they determine necessary for my proper medical care.

FINANCIAL RESPONSIBILITY

I further authorize and request that insurance payments be made directly to Washington Hospital Healthcare System (Washington Hospital, Washington Township Medical Foundation, Washington On Wheels, Washington Urgent Care, Washington Outpatient Rehabilitation Center, and Washington Radiation Oncology Center). My signature on this form acknowledges that I agree to bear full financial responsibility for all services provided that may not be covered by my insurance for the following reasons; not a covered benefit, not referred or authorized, or determined not to be eligible for coverage with Washington Hospital Healthcare System. I am aware that there is a \$25.00 fee for any appointments that I miss and had not contacted the office to cancel. I am aware that I have the right to appeal the insurance company's determination. If a denial is received, I will be responsible for the amount of this bill.

I have been offered a copy of the *Washington Hospital Healthcare System Notice of Privacy Practices*. By signing this Registration Form, I consent to the use and disclosure of my protected health information for the purpose of treatment, payment, and healthcare operations.

I hereby state that the information I listed above is accurate and complete. I acknowledge that I am responsible for notifying WHHS of any changes made to my contact information and/or insurance.

DATE

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY