Center for Transitional Neuro-Rehabilitation

(Please complete all sections and Print in black ink)

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial**

Date of Birth | **Social Security Number** | **Gender**

Ethnicity | **Race** | **Religious Preference?** | **Marital Status**

Hispanic/Latino/Spanish Origin ☐

Not of hispanic origin ☐

Home Address | **City** | **State** | **Zip**

Home Phone | **Work Phone** | **Cell Phone** | **Email**

Employment Status

Active Duty Military ◯ **Employed Full Time** ◯ **Not Employed** ◯

Disabled ◯ **Employed Part Time** ◯ **Retired** ◯

Student ◯ **Homemaker** ◯ **Self Employed** ◯

Employer | **Occupation** | **Employer Address** | **Employer Phone**

Diagnosis | **Date of Injury/Illness** | **State of Accident/Injury**

Type of accident: **Auto** ◯ **Illness/Condition** ◯ **Other** ◯ **Workers' Comp** ◯

Workers' Comp Claim #:

Are you in litigation due to this injury or condition: **Yes** ◯ **No** ◯

If yes, who is representing you?

Do you have an Advanced Directive, e.g., medical power of attorney? **Yes** ◯ **No** ◯

If yes, have you provided a copy to the hospital? **Yes** ◯ **No** ◯

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician | **Phone** | **Referring Physician** | **Phone**

PRIMARY INSURANCE INFORMATION (give your insurance cards to receptionist)

Primary Insurance Company | **Policy ID** | **Group Number** | **Phone Number**

Subscriber's Name | **Subscriber's Date of Birth** | **Subscriber's SSN**

Subscribers's Address | **City** | **State** | **Zip**

Patients Relationship to Subscriber **Self** ◯ **Spouse** ◯ **Child** ◯

Subscriber's Employer

Employer Address | **City** | **State/Zip** | **Employer Phone**

EMERGENCY CONTACT INFORMATION

Last Name | **First Name** | **Relationship to Patient**

Address | **City** | **State** | **Zip**

Home Phone | **Work Phone** | **Cell Phone**

SECONDARY INSURANCE INFORMATION (give your insurance cards to receptionist)

Secondary Insurance Company | **Policy ID** | **Group Number** | **Phone Number**

Subscriber's Name | **Subscriber's Date of Birth** | **Subscriber's SSN**

Subscriber's Address | **City** | **State/Zip** | **Phone**

Patients Relationship to Subscriber **Self** ◯ **Spouse** ◯ **Child** ◯

Subscriber's Employer

Employer Address | **City** | **State/Zip** | **Employer Phone**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to SJHMC. I understand that I am financially responsible for any balance. I also authorize the Center for Transitional Neuro-Rehabilitation and/or the insurance company to release any information required to process my claims.

Signature **Date**

It is the policy of St. Joseph's Hospital and Medical Center to comply with the requirements of federal (HIPAA) and state law and

In order to communicate your health status or permit any uses or disclosures of protected health information (PHI) to patient identified family and friends we need your oral or written permission.

☐ I permit St. Joseph's Hospital and Medical Center to share my protected health information with the following people:

_____

_____

_____

☐ I do not permit St. Joseph's Hospital and Medical Center to share my protected health information with any individual aside from myself.

Signature _____ Date _____
Patient Signature

Signature _____ Date _____
Patient Representative

Dignity Health.
St. Joseph's Hospital and Medical Center

FAMILY AND FRIENDS ACCESS TO PHI

NPP
X-MR-5441 (04/13)

Patient Label

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION VIA PUBLIC INTERNET

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name of Patient:_____ Date of Birth:_____

Other Names Used: _____ Telephone Number: _____

Medical Record or Account#:_____
(Hospital use only)

I AUTHORIZE :_____St. Joseph's Hospital and Medical Center (SJHMC)_____
(Facility or other provider)

TO DISCLOSE: Protected health information to me via unsecured email transmissions over the public internet. By this authorization I understand that my patient information may reside on public email servers and that my patient information may be inappropriately accessed by unauthorized third parties while in transmission via the Internet. I also understand that emails from my provider may be accidentally misdirected.

☑ **LIMITATIONS:** Emails between me, SJHMC Physicians and/or staff will be limited to inquries such as general health concerns, scheduling questions, and billing inquires.

PURPOSE: The purpose of the requested use or disclosure is:
☑ At the request of the patient or personal representative
☐ Continued healthcare

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different event or end date is specified: ____End of treatment relationship with SJHMC (or)_____
(insert event or date)

MY RIGHTS:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:
  Facility Privacy Officer, St. Joseph's Hospital & Medical Center
  350 West Thomas Road, Phoenix, AZ 85013

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by Arizona law and may no longer be protected by federal confidentiality law (HIPAA).

SIGNATURE: _____Date:_____
(Patient or personal representative)

_____ _____
Print name of personal representative Relationship to patient

Patient/Representative Identification Verified. *Initials:*_____ *Dept:*_____

Dignity Health.
St. Joseph's Hospital and Medical Center

PROTECTED HEALTH INFORMATION VIA PUBLIC INTERNET

NPP

X-MR-5822 (09/13)

Patient Label

Health Information Exchange (HIE) State Participation Acknowledgement

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding Dignity Health's participation in The Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

Acknowledgment
Signature: _____ Date: _____

If signed by anyone other than the patient, please indicate relationship:

Print Name: _____ Relationship: _____

Joint Notice of Privacy Practices for Health Information (NPP) and Patient Rights and Responsibilities Acknowledgement

Effective April 14, 2003 the law requires that **St. Joseph's Hospital and Medical Center** give to a patient a copy of its Notice of Privacy Practices for Health Information. This notice describes how medical information about you may be disclosed and how you can get access to this information. We will give you a copy at the time of first treatment and, if we change our notice, thereafter at the next treatment visit. By signing below, you acknowledge receipt of such as the patient, the patient's personal representative, the patient's authorized agent, or an individual involved in the patient's medical care.

We are also providing you a copy of the Patient Rights and Responsibilities, including the rights of visitation which are: You have the right to visitors or support persons without regard to age, race, creed, color, ethnicity, national origin, religion, sex, gender identity, sexual orientation, disability, veteran status, socio-economic, immigrant status or source of payment. You have the right to choose who may visit you during your stay and the right to withdraw that choice at any time. By signing below, the patient acknowledges receipt of such, or if you are the patient's personal representative, or authorized agent, or involved in the patient's medical care, you acknowledge receipt of such.

Patient Name: _____ Medical Record # _____
Acknowledgment
Signature: _____ Date: _____
If signed by anyone other than the patient, please indicate relationship:

Print Name: _____ Relationship: _____

OFFICAL USE:

I provided a copy of the NPP to the patient/patients representative but was unable to obtain his/her written acknowledgement of receipt of such for the following reasons:

_____

_____

I have attempted to provide to the patient/patients representative a copy of the NPP, but was unable to do so for the following reasons:

_____

_____

Signature of
Hospital Representative: _____Date:_____

Print Name: _____Department: _____

Dignity Health.
St. Joseph's Hospital and Medical Center

Health Information Exchange (HIE)
and Notice of Privacy Practices (NPP)