LAFAYETTE REGIONAL HEALTH CENTER
REGISTRATION FORM

LEXINGTON MEDICAL CLINIC   HIGGINSVILLE MEDICAL CLINIC
ODESSA MEDICAL GROUP

Patient's Information: *Date:* _______________

Legal Name: First______________________M.I.___Last______________________
Sex: M or F Patient's SS#__________________Date of Birth__________________
Address____________________________City___________State ____Zip_________
Patient's Home Phone (___)___________Cell/Other Phone(___)________________
Marital Status: S M D W Are you employed? Y or N Full-time or Part-time
Employer_________________________________
Employer Phone (___)________________

Race: (circle one) AfricanAmerican Hispanic AmericanIndian Asian White Decline
Ethnicity: (circle one) Hispanic/Latino Not Hispanic/Latino Decline
Language: (circle one) English Spanish Other ______________________
E-mail address: ___________________________

Emergency Contact ____________________________Relation to patient: _____________
Home Phone: __________________ Cell Phone:___________________________

Responsible Party: (Please send statement to)

Relationship to Patient: Self Spouse Parent Other____________________
Name: First_______________________________M.I._____Last_________________
Address____________________________City___________State___ Zip________
SS#__________________Date of Birth_________Home Phone (___)_____________
Cell/Other Phone (___)________________Occupation________________________
Employer____________________________Work Phone (___)__________________

Primary Insurance Information:
Name of Insurance Company___________________Employer______________________
Certificate/ID No.______________________Group/Policy No.____________________
Cardholder's Name______________________SS#____________Date of Birth___________

Secondary Insurance Information:
Name of Insurance Company___________________Employer______________________
Certificate/ID No.______________________Group/Policy No.____________________
Cardholder's Name______________________SS#____________Date of Birth___________

PLEASE COMPLETE REVERSE SIDE

LAFAYETTE REGIONAL HEALTH CENTER RURAL HEALTH CLINICS (LRHC RHC)

Patient Consent Form

(*Please Read and Sign*) ____

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/test and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.
I intend this consent to be continuing on nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **LRHC RHC** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **LRHC RHC** will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to the **LRHC RHC.**

I consent to photographs and/or images of me being recorded for security purposes. I understand that the facility retains the ownership rights to the images. I will be allowed to request access to or copies of the images when technologically feasible unless otherwise prohibited by law. I understand that these images will be securely stored and protected. ***Patient Initial ___________***

I acknowledge that I have been given the LRHC RHC Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. ***Patient Initial: _____________***

Advance Directive: Yes ___ No ___ (if yes, patient must provide copy for file)
Advance Directive Form: Accepted _____ Declined _____

Primary pharmacy: ____

I authorize **LRHC RHC** to release medical and psychiatric information to:

______________________________________	______________________________________
Print Name –Relation to patient	Print Name –Relation to patient
______________________________________	______________________________________
Print Name –Relation to patient	Print Name –Relation to patient

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

______________________________________ ________________________

Patient or Legal Guardian/Representative’s Signature Date