Shipyard Medical Center

Patient Name _____ Date of Birth ____/____/_____
(First) (Middle) (Last)

Address _____ _____ City _____ State____ Zip_____

Home Ph: _____-_____-_____ Cell Ph: _____-_____-_____ Work Ph: _____-_____-_____

Social Security _____-_____-_____ Sex: M F Email address_____

Place of Employment _____

Emergency Contact _____ _____Ph: _____-_____-_____

Preferred Pharmacy/Location and Phone Number_____

Policy Holder's Name_____DOB_____SSN_____-_____-_____

HIPAA Privacy Practices Acknowledgment

I have received a copy of Shipyard Medical Center's HIPAA privacy notice that explains how my Protected Health Informatio (PHI) may be used. Additional copies of the Notice of Privacy Practices are available at the front desk. Questions about our Notice of Privacy Practices may be directed to: Attn: Privacy Officer Shipyard Medical Center, 2632-3 Carolina Beach Road, Wilmington, NC 28412.

I acknowledge receipt of Shipyard Medical Center's privacy practices. In addition, my medical information **may be** shared with the individuals listed **below**. (Please exclude any doctors)

1) _____/_____ _____ 3) _____/_____ _____
Name / Relationship Phone Name / Relationship Phone

2) _____/_____ _____ 4) _____/_____ _____
Name / Relationship Phone Name / Relationship Phone

- ○ **Please check this box if it is OK to leave a message on your answering machine that contains Private Heath Info**
- ○ **Please check this box if you *do not* want us to disclose your Private Health Information to anyone**

X_____ _____
Patient Signature Date

Consent for Treatment: I hereby authorize the performance of medical treatment that may be advised or recommended by S M C, including necessary and/or beneficial services and use of equipment in the performance of the treatment.
Financial Agreement: I understand that Shipyard Medical Center files insurance as a courtesy and that I am ultimately responsible for payment for the services provided. I authorize Shipyard Medical Center to furnish any necessary information to insurance carriers concerning my illness/treatment and request payment be made directly to Shipyard Medical Center.

X_____ _____
Patient Signature Date

2632-3 Carolina Beach Road Wilmington, NC 28412-1806
Phone 910-794-3939 Fax 910-794-3938