FINANCIAL RESPONSIBILITY

I agree that I am financially responsible for all charges related to services provided by Pioneer Memorial Hospital & Health Services (PMHHS). I also agree to abide by PMHHS' payment guidelines, including payment of any periodic late fees. If I have questions about my financial responsibility for PMHHS' charges, or would like to see a copy of the Collection Policy; I may contact PMHHS' Patient Financial Services

Further, if I am provided health care services by a health care provider other than PMHHS, while a patient within a PMMHS facility or entity, I am financially responsible for all charges related to services provided by those health care providers. PMHHS' billing statements will not include charges by health care providers who are independent of PMHHS.

Additionally, I agree PMHHS, or its third party vendor, may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

ASSIGNMENT OF PAYER BENEFITS

I agree PMHHS and my attending health care provider will bill and provide necessary health information to any Payers. "Payers" are any health care insurance, private or government health plan or insurance policy that I have or another third party that will pay the charges I have incurred. All Payers may make payments directly to PMHHS and my attending health care provider. My signature on this form is my authorized signature for the filing of a claim and request for direct payment of benefits by any Payer to PMHHS and my attending health care provider. I agree that unless PMHHS or my attending health care provider have agreed with the Payer to accept payment from the Payer as full payment, I am responsible to pay any charges not paid by the Payer. These charges can include but are not limited to co-pays, deductibles, co-insurance amounts and charges for non-covered services.

MEDICARE BENEFICIARY REQUEST FOR PAYMENT AND ASSIGNMENT OF BENEFITS

If I am a Medicare beneficiary, I request that payment of authorized Medicare benefits be made on my behalf to PMHHS and my attending health care provider for any services furnished me by PMHHS and my attending health care provider, including physician services. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits for related services.

ACKNOWLEDGMENT

I have read the information above, and I have had the opportunity to ask questions and have them answered to my satisfaction. If I am not the patient identified in the below label on this form, I represent that I am authorized by law to agree to these conditions on the patient's behalf and am the authorized representative of the patient. A copy of this form is as effective and valid as the original.

_____ _____ _____a.m./p.m.

Signature of Patient or Authorized Person | Date | Time

_____

Relationship to Patient (if not patient signing)

Patient name _____ _____
Legal name Last First Middle initial Soc. Sec. #

Alternative names/maiden/nicknames _____ Hispanic/Latino Ethnical Background ☐ Yes ☐ No

Sex ☐ Male ☐ Female Birth date _____ Race _____

Marital status ☐ M ☐ S ☐ Divorce ☐ Widowed ☐ Separated Email _____

Address _____
Street PO Box City State Zip

Home phone ( )	Work phone ( )	Cell phone ( )
Employer	Occupation	

Employer address _____
Street PO Box City State Zip

Spouse's name	Birth date	Soc. Sec. #
Employer	Occupation	
Work phone ( )	Cell phone ( )	

Employer address _____
Street PO Box City State Zip

RESPONSIBLE PARTY / BILLING INFORMATION (If patient is a minor)

Mother's name	Birth date	Soc. Sec. #
Address _____ Street PO Box City State Zip		Home phone ( )
		Work phone ( )
Employer	Occupation	Cell phone ( )

Employer address _____
Street PO Box City State Zip

Father's name	Birth date	Soc. Sec. #
Address _____ Street PO Box City State Zip		Home phone ( )
		Work phone ( )
Employer	Occupation	Cell phone ( )

Employer address _____
Street PO Box City State Zip

EMERGENCY CONTACT

Name	Relationship to patient

Address _____
Street PO Box City State Zip

Home phone ( )	Work phone ( )	Cell phone ( )

Pioneer Memorial
Viborg Medical Clinic
SANFORD

PATIENT INFORMATION

VMC 2005
Revised 05/30/14

NAME _____

DOB _____

Your health data is stored in an electronic medical record known as One Chart. One Chart is used by this health care provider and others we have a direct relationship with. This form explains how your health record in One Chart is shared with friends, family and other unrelated health care providers. This is called disclosure and happens for:

Friends and Family
Privacy laws allow verbal (spoken) health data to be shared with family and close personal friends. This sharing is allowed when family and friends are directly involved in a patient's care or payment for care. Please ask staff at the reception desk to limit that sharing if you have concerns about family and friends getting your health data. Family and friends may not receive copies of your records without your consent.

Payers for Payment
Privacy laws allow health data related to services received to be shared for payment. This means your health record may be shared with your health insurance company or other sources that help pay your bill.

- I agree to tell my health care provider when I arrive if I do not want records from that visit to be shared for payment. I understand that payment must be made by me alone.

From Payers and Networks
Your health insurance company may want to share your health data with us to improve the quality of your care. This may include your records from past, current and future treatment at other health care providers.

- I agree that my health insurance company network including accountable care organizations may share my health and account records from any other sources with my current care provider.

Health Care Providers for Treatment
Health data can be shared between health care providers to help with your care, especially in an emergency.

- I consent to share my health record with other health care organizations directly involved in my current or future treatment. This sharing may occur on paper or by electronic means. This sharing includes regional or national health information exchanges (health care provider groups). This consent does not include sharing of records by or from a drug or alcohol abuse treatment program unless I have given that program written consent.

This consent will be forever unless you stop it by writing our medical records department. Stopping this consent will not change releases that have already been made.

Patient or Legal Representative Signature	Date	Time

Relationship to Patient (if signing for patient)

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed and outlines my rights with respect to such information. I understand that I should read it carefully.

I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice from any Pioneer Memorial Hospital & Health Services location, or on our website at www.pioneermemorial.org.

I certify that I understand and authorize the above information.

Patient signature _____

Or/by _____

Relationship to patient _____

Employee's initials _____ Date _____

Pioneer Memorial Hospital & Health Services
SANFORD
315 N. Washington•Viborg, SD 57070
605-326-5161 Fax: 605-326-5734
www.pioneermemorial.org

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

BUS 1065

Revised 6/25/15

Patient name _____

DOB _____

Med Record # _____