TO BE SCANNED

SCAN - EMR

Demographics, Authorizations & Financial Responsibility

MRN#____________________

First Name:	MI:	Last:
Street Address:		
City: State:	County:	Zip Code:
Home Phone:	Cellular:	Work:
E-Mail Address: Do we have permission to send you occasional e-mails/materials regarding CARTI publications and/or notification of CARTI patient programs, special events and giving opportunities? ☐ Yes ☐ No	Primary Care Physician:	

Authorization to Disclose Treatment Related Information

- How would you prefer we communicate with you? ☐ Mail ☐ Phone ☐ Email
- Do we have your permission to leave a message/voicemail at the phone numbers listed above? ☐ Yes ☐ No
- Do we have your permission to discuss information pertaining to your diagnosis and continuing care with your family? ☐ Yes ☐ No

  If yes: Name:______________________________Relationship:_____________________ Phone:________________
  Name:______________________________Relationship:_____________________ Phone:________________
  Name:______________________________Relationship:_____________________ Phone:________________

Gender: ☐ Female ☐ Male
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other (specify):

Social Security Number: Date of Birth: STATE of Birth:

Language Preference: ☐ English ☐ Spanish ☐ French ☐ German ☐ Other (specify):

Race:	Ethnicity:
☐ Caucasian ☐ Black or African American ☐ Hispanic ☐ Native American	☐ Hispanic or Latino
☐ American/Alaska Indian ☐ Japanese ☐ Native Hawaiian	☐ Non-Hispanic or Non-Latino
☐ Pacific Islander ☐ Filipino ☐Asian ☐ Other, Undetermined	☐ Other or Undetermined

Employment Status: ☐ Employed ☐ Not Employed ☐ Retired	Occupation:	Employer:

Primary Insurance Company:___________________________ Policy #:__________________ Group #:______________

Policyholder's Name:___________________________ DOB: ________________ Relationship to patient:____________

Plan address & telephone #:____

Secondary Insurance Company:_______________________ Policy #:__________________ Group #:______________

Policyholder's Name:___________________________ DOB: ________________ Relationship to patient:____________

Plan address & telephone #:____

Financial Responsibilities, Assignment of Benefits and Authorization for use and disclosure of PHI:

- I have received a copy or provided access to CARTI's Notice of Privacy Practices.
- I understand I am financially responsible for any balance due to CARTI, as assigned by my insurance after claims have been processed.
- I authorize CARTI to obtain any financial information if financial terms are requested.
- I authorize CARTI to receive payments from my insurance company or companies on my behalf.
- I authorize CARTI and my insurance company to release medical data including Private Health Information (PHI) as needed or required in order to process my insurance claims.
- I authorize CARTI to release the minimum necessary personal health information to any entity that assists in funding of any supportive services and/or financial assistance.

My Signature indicates I have read and understand the above statements and consent to each:

____ ___________________________

Signature of Patient or Guardian (relationship to patient) **Date**

Revised 1/1/2016, 1/1/2017, 9/19/2017