

DEERS INFORMATION CHECKED BY PAD Representative					
ID CARD NUMBER (use sponsor's number)		EXPIRATION DATE:		ELIGIBILITY	
PATIENT'S SOCIAL SECURITY NUMBER	DATE OF BIRTH (Day,Month,Year)	SEX:	AGE:	Signature of PAD Representative	

PART III SPONSOR INFORMATION (IF YOU ARE ACDU OR RETIRED – YOU ARE YOUR OWN SPONSOR)					
SPONSOR'S LAST NAME		FIRST NAME:		MIDDLE:	
SSN:	RATE/RANK:	DESIG/MOS/AFSC	TIME IN SERVICE:	FLY STATUS:	BRANCH OF SERVICE:
LOCAL UIC:	COMPLETE MILITARY ADDRESS (SHIP-STATION-UNIT-DIVISION-FPO/FP-NAVY RECRUITS CO.NO MARINE RECRUITS CO/NO/BN/PLT)				
DUTY STATION PHONE NUMBER ()	IS ACDU MILITARY SPONSOR: <input type="checkbox"/> STAFF <input type="checkbox"/> STUDENT <input type="checkbox"/> INSTRUCTOR				

PART IV EMERGENCY DATA OF PRIMARY NEXT OF KIN FOR PATIENT		
NAME: (Last, First, Middle)		RELATIONSHIP:
ADDRESS (Street) <input type="checkbox"/> Same as Patient		HOME PHONE: ()
CITY	STATE	ZIP CODE

PART V ACCIDENT/INJURY INFORMATION	
IF INJURED WERE YOU <input type="checkbox"/> ON DUTY <input type="checkbox"/> OFF DUTY <input type="checkbox"/> OTHER THAN ACTIVE DUTY MEMBER	
EXPLAIN:	TIME AND DATE OF ACCIDENT
IF MOTOR VEHICLE ACCIDENT, WERE YOU <input type="checkbox"/> DRIVER <input type="checkbox"/> PASSENGER	WERE YOU TRANSFER FROM ANOTHER HOSPITAL? <input type="checkbox"/> YES <input type="checkbox"/> NO
ORIGINAL ADMISSION DATE:	NAME OF TRANSFERRING HOSPITAL:

TITLE 18 USC, SECTION 1001. Statements or entries generally:

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry shall be fined not more than \$10,000 or imprisoned not more than five years, or both.

I HAVE READ AND UNDERSTAND; SECTION 1001 TITLE 18 USC, QUOTED ABOVE AND I CERTIFY UNDER PENALTY OF LAW THAT ALL INFORMATION ON THIS FORM IS TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE:	DATE:
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NAVAL MEDICAL CENTER SAN DIEGO CALIFORNIA

PATIENT: _____ DATE OF BIRTH: _____ SPONSORS SSN: _____

GENERAL CONSENT TO TREATMENT

- 1. I consent to undergo all necessary routine tests, medication, treatment and other procedures required in course of the study, diagnosis and treatment of my illness by the staff and other agents and/or employees of the Naval Medical Center San Diego including medical students. I understand that this is a teaching medical center and that training doctors is one of the activities of the medical center.
2. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to meet as the result of my treatment or examination in the medical center.
3. I consent to the release of medical information to the other institutions or agencies accepting me as a patient for medical treatment, and to the release of medical information to my insurer that is necessary for treatment, payment or healthcare operations.
4. I hereby authorize the release of my Social Security Number to a manufacturer of medical equipment in the event I receive a medical device in accordance with federal law and regulations. I further understand that if there is a need to contact me with regard to this device my Social Security Number may be used by the manufacturer to help locate me.
5. I understand that access to medical records for bona fide research and quality assurance is permitted to members of the medical and medical center staff. I authorize my medical records and results to be used for research. I realized that my records will not be identified as pertaining to me specifically without my expressed permission.
6. I further understand that:
a. No patient will be involved in any research or experimental procedure without his or her full knowledge and consent; and
b. Each patient has the right to consent, or to refuse consent, to any proposed procedure or therapeutic course; and
c. The possibility exists that during my hospitalization, health care workers may be directly exposed to my blood and body fluids. In the event of such a direct exposure in a manner which may, according to the Centers for Disease Control guidelines, transmit AIDS (Acquired Immune Deficiency Syndrome), and the other blood borne diseases, a sample of my blood will be tested for the presence of infectious disease such as hepatitis, syphilis, and AIDS. I further understand that the results of the tests will be released to me and to any healthcare worker who suffered the exposure.
7. I agree to abide by the rules of the medical center, including to the extent I am able, cooperation with the physician in my care and treatment, and observance of the rights of the other patients.
8. Title 10 of the U. S. C. Sections 1075 and 1078 require the Secretary of Defense to collect charges for inpatient general medical care provided in a Military Treatment Facility (MTF). This charge will be collected from all active duty, retired officers, and family members for each day of hospitalization. Enlisted retirees and TRICARE Prime family members of active duty are exempt from charges. The following is a schedule of the daily charges for the current fiscal year. Active Duty: No charge. Retired Service Member: No charge. Family Members of Active Duty enrolled in Prime: No charge. Family Members of Active Duty not enrolled in Prime and Family Members of Retirees: \$17.35.
9. There will be a charge for all meals provided to patients receiving outpatient services. A patient who requests food service, or who is offered and accepts food service delivery, and who has not been admitted to the MTF, shall be considered a patron of the dining facility and charged for each meal received at the current rate. The Office Management and Budget, Washington, D.C. establishes meal rates annually. Meal rates for current fiscal year are: Breakfast: \$2.10 Lunch: \$3.85 Dinner: \$3.85

This form has been fully explained to me, and I am satisfied that I understand its content and significance.

Patient or Legal Guardian Signature

Date

Witness Signature

Date

ADVANCE DIRECTIVE AND PATIENT RIGHTS ACKNOWLEDGEMENT

You have the right to make decisions regarding your medical care. You also have the right to appoint someone to make medical decisions for you if you are unable to make those decisions yourself.

An "Advance Directive" is a written instruction, such as a living will or durable power of attorney for health care, relating to the provisions of health care when the individual is incapacitated.

It is Naval Medical Center policy to inform patients of the availability of living wills and durable powers of attorney for health care which direct the staff not to perform excessive measures in terminal or otherwise appropriate cases. Please ask your nurse or physician about an advance directive if interested. Provision of care is not conditioned on whether an individual has executed an advance directive.

PLEASE READ THE FOLLOWING STATEMENTS, CIRCLE THE APPROPRIATE CHOICES, AND SIGN BELOW

1. I have been given written materials about patient rights and responsibilities.
2. I have been informed of my rights to formulate Advance Directives at any time.
3. I understand that I am not required to have an Advance Directive in order to receive treatment at this health care facility.
4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law. To facilitate compliance with the Advance Directive, I realize that this facility needs a copy within 24 hours of my admission. If unable to obtain a copy, I understand that I may execute (orally or in writing) another Advance Directive.
5. **I HAVE / I HAVE NOT** executed an Advance Directive.
6. **I DO / I DO NOT** wish to execute an Advance Directive at this time.

PATIENTS SIGNATURE: _____ DATE: _____

WITNESS NAME/SIGNATURE: _____ DATE: _____

COMPLETED BY ADMISSIONS STAFF WHEN PATIENT IS UNAVAILABLE AT TIME OF ADMISSION

The patient was unable to complete this form at the time of admission due to the following reasons:

ATTENTION TO PATIENTS! Please bring a copy of your Advance Directive to be filed in your Outpatient Medical Record and anytime you are admitted to the Hospital, if we do not have your copy of your Advance Directive, we may not be able to honor your wishes regarding life-sustaining procedures.

If you have additional questions, please contact NMCS Legal Department at (619) 532-6475.

RELEASE OF INFORMATION DISCLOSURE

You have the right to request about your admission to this hospital not to be released to outside persons. If you choose this restriction, individuals contacting the hospital inquiring about your presence or status in the hospital will not be given this information. However, this information will be released when necessary for treatment, payment or healthcare operations. You may choose to revoke this restriction at any time verbally or in writing, and it applies only to this admission.

If you have questions, you may call admissions at (619) 532-8366

I have been informed of my rights to have information about my admission restricted, and **I DO / I DO NOT** request this restrictions (please circle the appropriate choice)

PATIENT or LEGAL GUARDIAN SIGNATURE DATE

WITNESS NAME/SIGNATURE DATE

**THIRD PARTY COLLECTION PROGRAM/MEDICAL SERVICES ACCOUNT/
OTHER HEALTH INSURANCE**

(Read Privacy Act Statement before completing this form.)

OMB No. 0704-0323
OMB approval expires
Mar 31, 2013

The public reporting burden for this collection of information is estimated to average 3 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division, 4800 Mark Center Drive, Alexandria, VA 22350-3100 (0704-0323). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. **PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO REQUESTING MILITARY TREATMENT FACILITY.**

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC, Sections 1095 and 1079b; Executive Order 9397.

PRINCIPAL PURPOSE(S): Information will be used to collect from private insurers for medical care provided to the Military Treatment Facility (MTF) patient. Such monetary benefits accruing to the MTF will be used to enhance health care delivery in the MTF.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 USC 552a(b) of the Privacy Act, the information on this form will be released to your insurance company.

DISCLOSURE: Voluntary. Failure to provide complete and accurate information may result in disqualification for health care services from MTFs.

PATIENT INFORMATION

1. PATIENT NAME <i>(Last, First, Middle Initial)</i> x	2. SSN x	3. DATE OF BIRTH <i>(YYYY/MM/DD)</i> x
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4a. MAILING ADDRESS <i>(Include ZIP Code)</i> x	b. HOME TELEPHONE NO. x	
	5a. FAMILY MEMBER PREFIX x	b. SPONSOR SSN x

6a. PATIENT'S EMPLOYER'S NAME x	b. EMPLOYER TELEPHONE NUMBER x
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INSURANCE INFORMATION

7. DO YOU HAVE OTHER HEALTH INSURANCE? *(This includes employer health insurance benefits, other commercial health insurance coverage, and Medicare Supplement.)*

a. **YES.** *(Complete Item 8 and the remaining sections below.)*

b. **NO,** I am a DoD beneficiary and rely solely on TRICARE, Medicare, or Medicaid. *(Proceed to Item 12.)*

c. **NO,** but I am not a DoD beneficiary. *(Proceed to Item 11.)*

8. PRIMARY MEDICAL INSURANCE INFORMATION. If you have an insurance card that can be copied or scanned by the MTF representative, please provide it and proceed to Item 10; otherwise, please complete the blocks below.

a. NAME OF POLICY HOLDER <i>(Last, First, Middle Initial)</i>	b. DATE OF BIRTH <i>(YYYY/MM/DD)</i>	c. RELATIONSHIP TO POLICY HOLDER
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d. **POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER**

e. **INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER**

f. CARD HOLDER ID	g. POLICY ID	h. GROUP POLICY ID	i. GROUP PLAN NAME
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j. ENROLLMENT/PLAN CODE	k. INSURANCE TYPE	l. POLICY EFFECTIVE DATE <i>(YYYY/MM/DD)</i>	m. POLICY END DATE <i>(YYYY/MM/DD)</i>
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n. **(1) PHARMACY (Rx) INSURANCE COMPANY NAME, ADDRESS, AND TELEPHONE NUMBER**

(2) Rx POLICY ID	(3) Rx BIN NUMBER	(4) Rx PCN NUMBER
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9. SECONDARY MEDICAL INSURANCE INFORMATION. If you have an insurance card that can be copied or scanned by the MTF representative, please provide it and proceed to Item 10; otherwise, please complete the blocks below

a. NAME OF POLICY HOLDER (Last, First, Middle Initial)		b. DATE OF BIRTH (YYYY/MM/DD)	c. RELATIONSHIP TO POLICY HOLDER		
d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER					
e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER					
f. CARD HOLDER ID	g. POLICY ID	h. GROUP POLICY ID	i. GROUP PLAN NAME		
j. ENROLLMENT/PLAN CODE	k. INSURANCE TYPE	l. POLICY EFFECTIVE DATE (YYYY/MM/DD)	m. POLICY END DATE (YYYY/MM/DD)		
n. (1) PHARMACY (Rx) INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER.					
(2) Rx POLICY ID		(3) Rx BIN NUMBER	(4) Rx PCN NUMBER		

10. ARE THERE OTHER FAMILY MEMBERS COVERED UNDER THIS POLICY HOLDER?

a. YES (Complete 10c. - e. and				b. NO (Proceed to Item 12.)			
c. NAME (Last, First, Middle Initial)	d. SSN	e. DATE OF BIRTH (YYYY/MM/DD)	f. RELATIONSHIP TO POLICY HOLDER	c. NAME (Last, First, Middle Initial)	d. SSN	e. DATE OF BIRTH (YYYY/MM/DD)	f. RELATIONSHIP TO POLICY HOLDER

11. MEDICARE OR MEDICAID INFORMATION

a. MEDICARE PART A NUMBER	b. MEDICARE PART B NUMBER	c. MEDICARE MANAGED CARE PLAN NAME	
d. MEDICARE PART D NUMBER AND PLAN NAME		e. MEDICAID NUMBER/MANAGED CARE PLAN NAME/ISSUING STATE	

12. CERTIFICATION, RELEASE, AND ASSIGNMENT

a. I certify that the information on this form is true and accurate to the best of my knowledge. Falsification of information is covered by Title 18, United States Code, Section 1001, which provides for a maximum fine of \$250,000 or imprisonment for five years, or both.

b. I acknowledge that the authority to bill third party payers has been conveyed to the medical facility within the Department of Defense by Title 10, United States Code, Sections 1095 and 1079b, and that no personal entitlement to reimbursement or payment has been granted to me by virtue of this act.

c. NON-DoD PATIENTS: I authorize and request that the proceeds of any and all benefits be paid directly to the MTF for healthcare services provided me and/or my minor dependents. ACKNOWLEDGEMENT: I hereby agree to pay for any service not covered in whole or in part by my third-party insurer.

d. NON-DoD MEDICARE PATIENTS: I acknowledge I am responsible for full payment of any services not covered by Medicare, including but not limited to patient copayments and deductibles.

e. DoD BENEFICIARIES: I hereby acknowledge that the proceeds of any and all benefits shall be paid directly to the facility of the Uniformed Service for services provided me and/or my family member.

f. ALL PATIENTS: I authorize portions of my medical records necessary to support claims for reimbursement for the cost of care rendered to be released to my insurance carriers.

13a. PATIENT OR ADULT FAMILY MEMBER SIGNATURE	b. DATE (YYYY/MM/DD)
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14a. IF PATIENT REFUSES TO SIGN THIS FORM: MTF REPRESENTATIVE SIGNATURE	b. DATE (YYYY/MM/DD)
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15. ANNUAL PATIENT INSURANCE VERIFICATION

a. If any information on this form has changed, a new form must be completed and signed. Otherwise, after initial signature, verify with your initials and date at least annually.

b. I certify that the information on this form has been verified on the date(s) specified below, and that all information is true and accurate to the best of my knowledge.

16a. SIGNATURE (Patient or Adult Family Member)	b. DATE (YYYY/MM/DD)
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17. VERIFICATION	(2) INITIALS	b.(1) DATE (YYYY/MM/DD)	(2) INITIALS	c.(1) DATE (YYYY/MM/DD)	(2) INITIALS
a. (1) DATE (YYYY/MM/DD)					

PRIVACY ACT STATEMENT – HEALTH CARE RECORDS

THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)

Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.

3. ROUTINE USES

The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

SIGNATURE OF PATIENT OR SPONSOR

SSN OF MEMBER OR SPONSOR

DATE