

Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

13256



8 - OTHER

000001

EMERGENCY ROOM REGISTRATION REG: 09/30/98 MR# [REDACTED]
ACCT# [REDACTED] EDP# [REDACTED]

PT: [REDACTED] SEX F MS MARRIED DOB [REDACTED] AGE 38Y
RACE X SS# [REDACTED] RELG UNK UNKNOWN
PREV AD 08/11/98
COUNTY: [REDACTED] PREV DIS [REDACTED]
EMPL: [REDACTED]
H=PH: [REDACTED]
W-PH: [REDACTED]

DOC [REDACTED] CNS DOC [REDACTED]

OP TYPE: EMRGY OP SERV: ER INFO YES SHOW YES PT TYPE E PT CLASS

CHIEF COMPLAINT: UPPER CHEST PAIN

GUAR: [REDACTED] REL: PATIENT SS# [REDACTED]
EMPL: [REDACTED]

[REDACTED] W-PH: [REDACTED]

EMERGENCY CONTACT: [REDACTED] REL: HUSBAND
NEAREST RELATIVE: H-PH: [REDACTED] W-PH: [REDACTED]
REL: [REDACTED]
SPOUSE NAME: H-PH: [REDACTED] W-PH: [REDACTED]
SPOUSE EEMPL: [REDACTED]

FINANCIAL CLASS: [REDACTED]
INS #1: [REDACTED] EFF DT: 9/30/98 EXP DT: [REDACTED]
POLICY #: [REDACTED] POL HLDR: [REDACTED]
POL HLDR SS#: [REDACTED] REL: PATIENT
EMPL/GRP: [REDACTED] CERTIF #: [REDACTED]
COMMENTS: PREV REG

INS #2: [REDACTED] EFF DT: [REDACTED] EXP DT: [REDACTED]
POLICY #: [REDACTED] POL HLDR: [REDACTED]
POL HLDR SS#: [REDACTED] REL: [REDACTED]
EMPL/GRP: [REDACTED] CERTIF #: [REDACTED]
COMMENTS: [REDACTED]

INS #3: [REDACTED] EFF DT: [REDACTED] EXP DT: [REDACTED]
POLICY #: [REDACTED] POL HLDR: [REDACTED]
POL HLDR SS#: [REDACTED] REL: [REDACTED]
EMPL/GRP: [REDACTED] CERTIF#: [REDACTED]
COMMENTS: [REDACTED]

REF AGENCY: [REDACTED] REF DOC: [REDACTED]

ACC INFO: CD: I ILLNESS DT/TM: 9/30/98 LOC: [REDACTED]
DESC: [REDACTED] WORK INJ: [REDACTED]
AMBULANCE: NO AMBULANCE NAME: [REDACTED] MEDICARE: X ANW: N
COMMENTS: [REDACTED]

000002

GIVEN BY: PREV REG

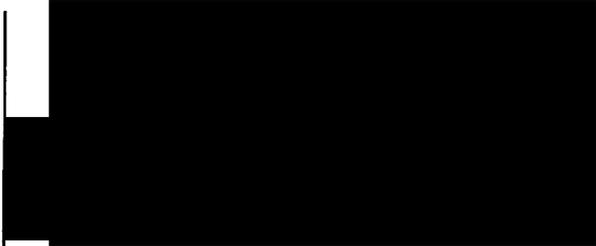
XXXXXXXXXXXXXXXXXXXX

PADM:

CFSAN #13256
03/02/99
MMF

Signature of Ordering Physician

[REDACTED]
Coded
Cleared



Please initial all that apply:

AUTHORIZATION TO RELEASE INFORMATION



I authorize this health care facility to release all medical information, including psychiatric/mental health, chemical dependency and/or AIDS related information to my HMO, insurance company, third party payer, or their designee, as may be necessary for the payment of my bill, determining benefits, or for utilization and quality review purposes for this episode of care.

I further authorize the release of this information to other health care agencies, professionals or persons, who may provide health care services deemed necessary for continuing my medical care.

CONSENT FOR TREATMENT



I authorize the performance of the diagnostic tests, procedures and treatments, and/or the administration of the medications which may be deemed appropriate by the physician, surgeon or other personnel involved in my care. I understand that persons receiving medical training may be involved in my care. I understand that most physicians are not employees or agents of this health care facility, but are independent contractors who have been granted privileges to treat patients in this health care facility. This consent for treatment includes the services which these physicians may perform as well.

I further understand and acknowledge that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me about the results of the examination and/or treatment to be provided in this health care facility.

CONSENT FOR RELEASE OF RECORDS FOR RESEARCH



I authorize this health care facility to release copies of my medical records for research purposes. I understand that I may revoke or limit this consent at any time by contacting the health care facility in writing.

HEALTH CARE FACILITY'S LIABILITY FOR PERSONAL PROPERTY



I understand and agree that this health care facility will not be responsible or liable for loss or damage to any money, jewelry, or other personal property or articles which are worn by the patient or kept in the patient's room or unit. This health care facility will assume responsibility only for those valuables delivered to health care facility personnel for storage in the facility's safe which delivery is reflected in a receipt provided to the patient.

ASSIGNMENT OF BENEFITS

000003



I assign to the health care facility all benefits payable to me for this care. I understand that the health care facility will be paid directly by the insurance company or other payer.

OVER FOR COMPLETE SIGNATURE

CFSAN #13256
03/02/99
MMF

AUTHORIZATION / CONSENT FORM

GUARANTEE OF ACCOUNT

I guarantee payment of all charges incurred for treatment and/or confinement of the patient in accordance with the rates and terms of this health care facility.

Signature of Patient or Responsible Party

Relationship to Patient

Reason Patient is Unable to Sign

**DUE TO CURRENT
MEDICAL CONDITION**

Date

9-30-98

For Medicare patients only

MEDICARE AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct. I authorize any holder of information about me to release to the Social Security Administration or its intermediaries or carriers, or to my insurance carrier or State MA Program, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. Information released may be used ONLY to process this claim and may not be re-released to anyone other than specified. For inpatient services, this authorization applies to this admission only. For outpatient services, I request that the authorization apply for a period of one year from date of registration.

I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare on my behalf.

If you do not want information about this medical claim released to a complementary insurance carrier or Title XIX, put an "X" in this box:

Beneficiary (Patient) Signature

Date

Beneficiary (Patient) Representative

Relationship

Date

Reason Patient Unable to Sign

000004

OUTPATIENT RE-REGISTRATION REG: 10/07/98 1430 MR# [REDACTED]
ACCT# [REDACTED] EDP# [REDACTED]

T: [REDACTED] SEX F MS MARRIED DOB [REDACTED] AGE 38Y
RACE X SS# [REDACTED] RELG UNK UNKNOWN
PREV AD 09/30/98, [REDACTED]
COUNTY: [REDACTED] PREV DTS [REDACTED]
EMPL: [REDACTED]

H-PH: [REDACTED]
W-PH: [REDACTED]

OC [REDACTED] CNS DOC [REDACTED]
P TYPE: DX SPD OP SERV: DXS INFO YES [REDACTED] YES PT TYPE 0 PT CLASS EMPLOYEE

DIAGNOSIS: PERICARDITIS
PROCEDURE: ECHO

UAR: [REDACTED] REL: PATIENT SS# [REDACTED]
EMPL: [REDACTED]
W-PH: [REDACTED]

EMERGENCY CONTACT: [REDACTED] REL: HUSBAND
H-PH: [REDACTED] W-PH: [REDACTED]
NEAREST RELATIVE: [REDACTED] REL: [REDACTED]
H-PH: [REDACTED] W-PH: [REDACTED]
SPOUSE NAME: [REDACTED] SPOUSE EMPL: [REDACTED]

FINANCIAL CLASS: [REDACTED]
INS #1: [REDACTED] EFF DT: 9/30/98 EXP DT: [REDACTED]
POLICY #: [REDACTED] POL HLDR: [REDACTED]
POL HLDR SS#: [REDACTED] REL: PATIENT
EMPL/GRP: [REDACTED] CERTIF #: [REDACTED]
COMMENTS: PREV REG

INS #2: [REDACTED] EFF DT: [REDACTED] EXP DT: [REDACTED]
POLICY #: [REDACTED] POL HLDR: [REDACTED]
POL HLDR SS#: [REDACTED] REL: [REDACTED]
EMPL/GRP: [REDACTED] CERTIF #: [REDACTED]
COMMENTS: [REDACTED]

INS #3: [REDACTED] EFF DT: [REDACTED] EXP DT: [REDACTED]
POLICY #: [REDACTED] POL HLDR: [REDACTED]
POL HLDR SS#: [REDACTED] REL: [REDACTED]
EMPL/GRP: [REDACTED] CERTIF #: [REDACTED]
COMMENTS: [REDACTED]

REF AGENCY: [REDACTED] REF DOC: [REDACTED]

CC INFO: CD: I ILLNESS DT/TM: 9/30/98 LOC: [REDACTED]
WORK INJ: [REDACTED] EMPL: [REDACTED]
AMBULANCE: NO AMBULANCE NAME: [REDACTED]
COMMENTS: [REDACTED]

ISSUED BY: PREV REG CHART PATIENT ACCOUNTING
CFSAN #13256
03/02/99
Signature of Ordering Physician [REDACTED]
000005
Exhibit 1, page 15 of 18

[REDACTED]
Coded
Cleared