APPALACHIAN
Regional Healthcare System

Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

APPFaithHealth

Member Registration Form

For Office Use Only

MRN#: _____

AFH#: _____

By signing this, I agree to be a participant in AppFaithHealth. This agreement allows Appalachian Regional Healthcare System to disclose to the clergy leader, liaison, or official representative of my congregation my name, general condition (not to include specific medical information) and my location in the facility when hospitalized. It also means I will have access to coordination services at the medical center to make sure I have everything I need for managing my illness and recovery process. It is understood that I may choose to opt out of the program at any time by contacting the Pastoral Care Department at 828-266-1178.

(Please Complete In Ink)

Full Legal Name:_____
(please print)

Date of Birth:_____ Phone: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Congregation: _____

Signature:_____ Date:_____ Time: _____

Effective Date: 11/13/2015
Revised Date: 11/23/2015
Form Number: 11049

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