MEMORIAL HEALTH SYSTEM
Heartland Health Care Clinic
ABILENE Salina Regional Health Center

REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____ Sex: _____

Birth Date: _____ SSN: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address (if different than mailing address): _____

City: _____ State: _____ Zip: _____

Preferred Phone: (_____) _____-_____ Alternate Phone: (_____)_____

E-mail: _____ Access to "My Health Portal"___Y___N

Marital Status: (___) Single (___) Married (___) Widowed (___) Divorced (___) Other: _____

Ethnicity: _____ Religion: _____

Preferred Language: (___)English (___)Spanish (___) Other: _____

EMPLOYMENT

(___) Full-time (___) Part-time (___) Retired (___)Self-Employed (___)Unemployed (___)Disabled (___)Minor

Employer: _____

Address: _____

City: _____ State:_____ Zip: _____ Phone: _____ (Ext:_____)

PERSON RESPONSIBLE FOR BILL

(___) Same as Patient (___) Parent/Guardian* (___) Other*: _____

If other than patient please fill in the following information

Name: _____ Relation: _____

Birth Date: _____-_____-_____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Emp. Status: (___) Full-time (___) Part-time (___) Retired (___) Self-Employed (___) Unemployed (___) Disabled

Employer: _____

Address: _____

City: _____ State:_____ Zip: _____ Phone: _____ (Ext: _____)

Preferred Provider: _____

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INSURANCE

***** Please present insurance cards at time of appointment *****

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Effective Date: _____-_____-_____ Co-Pay: $_____

Policy Holder: (___) Same as Patient (___)Spouse (___)Parent/Guardian (___) Other:_____

****If other than patient please fill in the following information****

Name of Subscriber (policyholder): _____

Subscriber Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____Cell Phone: (_____) _____-_____

Subscriber DOB: _____-_____-_____Subscriber SSN: _____

Subscriber Employment Status:
(___)Full-time (___)Part-time (___)Retired (___)Self-Employed (___)Unemployed (___)Disabled

Subscriber Employer: _____

Address: _____

City: _____State:_____Zip: _____Phone: _____(Ext: _____)

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Effective Date: _____-_____-_____ Co-Pay $_____

Policy Holder: (___)Same as Patient (___)Spouse* (___)Parent/Guardian* (___)Other*:_____

****If other than patient or primary insurance subscriber please fill in the following information***

Name of Subscriber (policyholder): _____

Subscriber Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____Cell Phone: (_____)_____

Subscriber DOB: _____-_____-_____ Subscriber SSN: _____

Subscriber Employment Status:
(___)Full-time (___)Part-time (___)Retired (___)Self-Employed (___)Unemployed (___)Disabled

Subscriber Employer: _____

Address: _____

City: _____State:_____Zip: _____Phone: _____(Ext: _____)

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INSURANCE

I hereby authorize my provider to furnish my insurance company or its representative or permit my insurance company or its representative to review any information requested with respect to any illness or accident, medical history or copies of hospital and medical records. A photo static copy of this authorization shall be considered as valid as the original. I hereby authorize payment directly to my provider for this illness or injury, of the provider's benefits otherwise payable to me, but not to exceed my indebtedness to said provider. I agree to pay the provider for all my charges whether or not covered by this assignment. The responsible party hereby agrees that the provider's office or the party responsible for the billing of these services may check credit with any source to obtain credit information. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This release may include information which may be considered a communicable or venereal disease which may include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS). I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and granted the request of authorizations.

I have been notified that I may receive services from the Advanced Practice Provider at this location.

PLEASE NOTE: The patient portion of the bill is due at the time of service unless prior arrangements have been made.

x_____ **x**_____

Patient or Authorized Person's Signature *Date/Time*

MEMORIAL HEALTH SYSTEM
Heartland Health Care Clinic
ABILENE Salina Regional Health Center

Salina Regional Health Center
Authorization to Verbally Release Protected Health Information
and Emergency Contact List:

I authorize Salina Regional Health Center, and all affiliates, and health care providers to provide verbal information concerning my health care to those that I have listed below while I am a patient. Verbal requests for information from other friends, family, and caretakers, concerning my health care will not be disclosed without additional authorization from me. (Exception: Health Information may be disclosed without authorization in an emergency situation or if SRHC determines that the disclosure is in my best interest and the information disclosed is limited to those persons involved in my care).

Emergency Contact

Contact Name	*Relationship to Patient*	*Phone Number*	*Allow Messages* ____Y ____N
Address	*City*	*State*	*Zip*

Additional Contacts
Include Emergency Contact listed above? _____Y _____N

Contact Name	*Relationship to Patient*	*Phone Number*	*Allow Messages* ____Y ____N
Address	*City*	*State*	*Zip*

Contact Name	*Relationship to Patient*	*Phone Number*	*Allow Messages* ____Y ____N
Address	*City*	*State*	*Zip*

Contact Name	*Relationship to Patient*	*Phone Number*	*Allow Messages* ____Y ____N
Address	*City*	*State*	*Zip*

Contact Name	*Relationship to Patient*	*Phone Number*	*Allow Messages* ____Y ____N
Address	*City*	*State*	*Zip*

I may revoke this authorization at any time by notifying my nurse. I have read the above and authorize verbal disclosure of my medical condition. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed and no longer protected by those regulations.

X______________________________ X____

Date *Signature of Patient or Authorized Agent/Representative*

____ ______________________________

Printed name of authorized agent/representative *Relationship to patient*

(Note: Any requests for restriction/communication accommodation should be forwarded to the Privacy Office for approval on the "Request for Disclosure Restriction/Communication Accommodation Form")

MEMORIAL HEALTH SYSTEM
Heartland Health Care Clinic
ABILENE Salina Regional Health Center

Health History Form

Personal Medical History *(check to the left of all that apply)*

HEENT

☐	Allergies	☐	Vision Deficit	☐	Recurring Sinus Infections	☐	Vision Loss	☐	Retinopathy
☐	Cataracts	☐	Hearing Deficit	☐	Recurring Ear Infections	☐	Glaucoma	☐	Hearing Loss

Endocrine

☐	Diabetes	☐	Hypothyroidism	☐	Osteoporosis	☐	Pituitary Condition	☐	Goiter
☐	Hyperglycemia	☐	Hyperthyroidism	☐	Osteopenia	☐	Adrenal Gland Condition	☐	PCOS

Respiratory

☐	Asthma	☐	Sleep Apnea	☐	Shortness of Breath	☐	Chronic Bronchitis	☐	Pleural Effusion
☐	COPD	☐	Chronic Cough	☐	Pulmonary Hypertension	☐	Pulmonary Embolism	☐	Tuberculosis

Cardiovascular

☐	Chest Pain	☐	Palpitations	☐	Hypertension	☐	Atrial Fibrillation	☐	Myocardial Infarction
☐	Heart Attack	☐	Heart Murmur	☐	Hyperlipidemia	☐	Coronary Artery Disease	☐	Enlarge Heart

Gastrointestinal

☐	Celiac Disease	☐	Chronic Constipation	☐	Diverticulitis	☐	Polyps	☐	Hiatal Hernia
☐	Cirrhosis	☐	Diverticulosis	☐	Crohn's Disease	☐	GERD	☐	Irritable Bowel Syndrome

Genitourinary

☐	Kidney Stones	☐	Frequent nighttime urination	☐	Erectile Dysfunction (Male)	☐	Endometriosis (Female)
☐	Kidney Disease	☐	Urinary incontinence	☐	Testicular Problems (Male)	☐	Abnormal Pap Smear (Female)

Musculoskeletal

☐	Arthritis	☐	Chronic Back Pain	☐	Spinal Stenosis	☐	Carpal Tunnel Syndrome	☐	Rheumatoid Arthritis
☐	Gout	☐	Congenital Deformity	☐	Scoliosis	☐	Fibromyalgia	☐	Osteoarthritis

Hematology/Oncology

☐	Anemia	☐	Cancer (specify)_____	☐	Low platelet count

Infectious Disease

☐	AIDS	☐	Chickenpox	☐	Hepatitis	☐	Shingles	☐	Tuberculosis
☐	HIV	☐	Measles	☐	Rubella	☐	Syphilis	☐	Rheumatic Fever

Integumentary

☐	Acne	☐	Eczema	☐	Melanoma	☐	Lupus	☐	Psoriasis

Neurologic

☐	Autism	☐	Dementia	☐	Migraines	☐	Neuropathy	☐	Stroke
☐	Cerebral Palsy	☐	Head Trauma	☐	Multiple Sclerosis	☐	Seizures	☐	Tremor

Other Medical History:_____

Surgical History

Surgery	Year	Surgery	Year

Social History

Do you drink alcohol? (___)Yes (___) No Amount per day? _____

Have you ever used street or IV drugs? (___)Yes (___) No What kind?_____

Do you use tobacco products? (___)Yes (___) No (___) Former Amount per day:_____Quit Date:_____

Family Medical History

Relative	Health Issues	Age & Cause of Death
Mother		
Father		
Sibling		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Other		

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Prescription and Non-Prescription Medication List

Preferred Pharmacy:_____

Medication Name	*Dosage*	*How often do you take?*	*What is the medication for?*	*Prescribing Provider*

Allergies

Allergen	*Reaction*

Patient Rights and Responsibilities

The understanding of Patient Rights shall be given to every new patient.

As a patient, you have certain rights:

- It is your right to take an active role in your health care
- Your cooperation is important
- Understanding your rights will help you get the best care possible

You also have many decisions to make:

- Make the best choices
- Resolve any conflict that may arise
- Patient rights also help legal agents

You have the right to respectful care:

- Be informed
- Be treated with respect at all times
- Have privacy
- Receive clearly written and spoken information
- Have information about you kept confidential
- It is your right to be treated without discrimination

You have the right to informed consent:

- Before you give you OK to any procedure, test, or treatment, you should receive all the information you need to make a decision
    - Your options, the risks and benefits, possible outcomes, possible side effects, and costs
    - Get complete information
- Know who is providing your care
- Give your informed consent before taking part in special programs

You have the right to accept or refuse care:

- Decide for yourself
- Make advance directives
- Ask for a second opinion
- Receive pain relief

You also have other rights:

- See your medical records
- Have a patient advocate, if desired
- Be accepted for treatment
- Understand your bill

As a patient, you also have certain responsibilities:

- Follow all rules
- Treat others with respect
- Follow your health care provider's instructions
- Bring identification and insurance information
- Report any changes – address, phone, insurance
- Bring you advance directives, if you them
- Give full information
- Pay bills promptly
- Plan carefully and keep your own records

Financial Policy

Welcome to Heartland Health Care Clinic. We wish to make our time together as pleasant as possible. In order to accomplish this, we feel it is important to have an understanding of the financial policy.

We are preferred providers and participating physicians for many different insurance companies. This usually means we accept their allowed charge as the final charge to you. However, not all insurance companies pay their allowed charge in full. Different plans and policies have different deductibles and co-pays, which is the responsibility of the patient. We try our best to keep track of what different companies pay and the services they will cover; but please understand that due to the great number of insurance companies, it is impossible for us to know them all. Please refer to your own insurance carrier's policy manual, as it is your responsibility to know the policies of your insurance carrier.

We will submit all insurance claims if you provide us with complete and correct information. We will work closely with the insurance company to make sure correct payments are made on your claims. Please remember the policy contract is between you and your company. Therefore, you are ultimately responsible for your bill.

We will fill out disability forms and SRS medical statements for you. However, there will be a $10.00 charge for completion of disability forms for loan payments and SRS medical statements. This charge must be paid when the form is picked up, or before it is mailed to the company.

All co-pays must be paid at the time of service. Any amount not covered by insurance is due at the time the services are provided. All policies are different so some deductibles may not be known until the claims are processed by your insurance carrier. Therefore, any balance due from you will be due in full at the time of the first billing following insurance processing.

If you know there will be a balance due after insurance payment and you will not be able to pay in full at the time of the first billing, please talk to the Patient Financial Services department now. We accept Visa, MasterCard and Discover. Accounts that will take more than one month to clear will be placed on our payment plan. We will make payment arrangements with you.

If after 30 days, we have not received adequate payment on your account, or you do not meet your payment plan agreement, you will be placed in our collections process. After 90 days without adequate payment, we will turn your account over to a private collection agency and place your account on a cash only option for any future medical treatment at our clinic. Failure to make adequate payment on your account could eventually result in you being discharged from this clinic as a patient.

If you have any questions regarding the above information, your insurance coverage, or payment please see your account representative in the Patient Financial Services department at the time of your first appointment.

We look forward to working with you. Thank you for choosing Heartland Health Care Clinic for your medical needs!

MEMORIAL HEALTH SYSTEM
ABILENE | Salina Regional Health Center
Caring for you.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PRINT PATIENT'S FULL NAME _____
OTHER NAMES USED _____
BIRTHDATE _____
TELEPHONE NUMBER _____

I, _____, authorize _____ to disclose confidential health information from the above-named patient's health record to: **Heartland Health Care Clinic – 511 NE 10th St. Abilene, KS, 67410, or (Fax) 785-263-2774** for the following purpose: _____
_____.

The information to be disclosed is:

☐ All Records
- Anesthesia Record
- Billing Records
- Consultation Reports/Records
- Emergency Department Records
- History/Physical/Discharge Records
- Laboratory Records
- Nursing Notes/Records

☐ Clinic Records
- Operative Reports/Records
- Pharmacy Records
- Physical/Speech/Occupational Therapy Records
- Physician Notes/Records/Orders
- Psychotherapy Notes (need separate authorization)
- Respiratory Therapy Records
- Social Work Reports/Records
- Other

For treatment dates of _____.

I understand that my health information may contain information relating to: HIV, contagious diseases, psychiatric treatment, mental health treatment, substance treatment, or other conditions which may be specifically protected by law and I authorize disclosure of that information. I understand that once my health information has been disclosed, it will no longer be subject to federal privacy regulations and may be disclosed by the person receiving it.

I understand that I may refuse to sign this Authorization and that my treatment or payment for my treatment will not be affected if I do not sign this form unless my treatment includes research or the reason for my treatment is to disclose information to another person.

I understand that I may see and copy the information described on this form as provided by federal regulations, and that I will get a copy of this form after I sign it.

This authorization will expire on the following date or event: _____

I understand that I can revoke this authorization in writing but that any revocation is not effective for disclosures that have already been made. To revoke this authorization, I should contact:

HIPAA Privacy Officer
511NE 10th ST
Abilene, KS 67410
785-263-2100

I also authorize disclosure of the records upon presentation of a photocopy of this authorization.

_____ _____
Signature of Patient or Patient's Personal Representative Date

_____
Personal Representative's Relationship to Patient