REGISTRATION FORM

PATIENT INFORMATION

Please circle the requested physician:

Ziegler Thompson Hinman Brown Holmes Short Hicks

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: ______________________

Previous doctor: ________________________ Are you expecting (circle): Yes / No

List Chronic Medical Conditions:

____

____

____

____

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 provide: Name _________________________________ date of birth: ____________

SSN: __________________ phone number: ________________ employer: _____________________________

<u>Do you have immediate needs to be seen?</u> Yes / No

For office use only:
Physician's decision/acceptance: Yes / No Physician initials: ___________
New patient appointment scheduled: ______________________ by: _____________

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

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: ______)

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*

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
	Blood clots		Bleeding disorders		Other Heart problems:				

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
	ADD/ADHD		Bipolar		Anxiety disorders		Depression		Mental illness

Other medical conditions not listed above?

____

____

____

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 (including vaping, chewing, cigarettes, etc)?

(______) 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		

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

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!

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	☐ Operative Reports/Records
☐ Billing Records	☐ Pharmacy Records
☐ Consultation Reports/Records	☐ Physical/Speech/Occupational Therapy Records
☐ Emergency Department Records	☐ Physician Notes/Records/Orders
☐ History/Physical/Discharge Records	☐ Psychotherapy Notes (need separate authorization)
☐ Laboratory Records	☐ Respiratory Therapy Records
☐ Nursing Notes/Records	☐ Social Work Reports/Records
☐ Clinic 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