Saint Alphonsus Medical Group

PATIENT REGISTRATION: PATIENTS 18 YEARS AND OLDER

Date: __________________

Patient

Last Name ________________ First Name ________________ Initial ________

Date of Birth ____________ Gender: ☐ Female ☐ Male Email ____________________

Address ______________________ City ____________ State _____ Zip _______

Phone (Home) ____________________ Phone (Cell) ____________________

Phone (Work) ______________ Preferred Message/Contact Phone: ☐ Home ☐ Cell ☐ Work

Race (please circle) American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Other (Multi-racial) Unknown Declined

Ethnicity (please circle) Hispanic or Latino Not Hispanic or Latino Other ______________

Preferred Language ☐ English ☐ Spanish ☐ Other ______________________

Employer ______________________________________

Employer Address ____________________ City ____________ State _____ Zip _______

Have you been seen at a St Alphonsus Clinic or Express Care Clinic in the past 3 years? ☐ Yes ☐ No

Who is your current / past primary care provider? ________________________

Preferred Pharmacy____________________ Major Crossroads ____________________

Health Insurance

(Clinic: If unable to scan card, make copy and attach. If card unavailable, write info on this form.)

Primary Insurance __________________ ***(Employer ONLY needed if different from above.)***

Policy Holder Name ____________________ Date of Birth ____________________

Employer ______________________ Relationship to Patient ______________

Employer Address ____________________ City ____________ State _____ Zip _______

Secondary Insurance __________________

Policy Holder Name ____________________ Date of Birth ____________________

Employer ______________________ Relationship to Patient ______________

Employer Address ____________________ City ____________ State _____ Zip _______

Additional Contact (not living with you)

Last Name ________________ First Name ____________ Phone Number ____________

Address ______________________ City ____________ State _____ Zip _______

Relationship to Patient ______________________________________

Advanced Directives (Living Will)

Would you like more information about Advance Directives? ☐ Yes ☐ No

Brochure Provided? ☐ Yes ☐ No

People assisting with paperwork:

______________________ Interpreter's name

______________________ Interpreter's Signature and/or ID #

______________ Date and Time

______________________ Office Staff name

______________________ Office Staff Signature

______________ Date and Time

Place patient sticker here or handwrite

Name: ______________________

DOB: ______________________

Insurance/PR
Rev 07-11-2012
Form 0001

Saint Alphonsus Medical Group

ANNUAL HEALTH HISTORY

Place patient sticker or handwrite

Name: ______________________

DOB: ______________________

Today's Date: ______________

Name: ________________________________ **Date of Birth:** ________________ **Age:** ____________

Preferred Pharmacy Name: ________________________ **Pharmacy Location (Cross Streets):** ____________

Do you use Tobacco? ☐ Yes, Currently ☐ No, never ☐ No, I am a former tobacco user
Type of Tobacco Used: ☐ Cigarettes ☐ Chewing ☐ Other _______ How much per day: ________ Years used: _______
Have you ever tried to quit? ☐ Yes ☐ No Year Quit: ____________
Are you exposed to passive smoke? ☐ Yes ☐ No

Fall Risk: Have you fallen in the last year? ☐ Yes ☐ No Number of Falls/past year? ____________
Do you have problems with walking or balance? ☐ Yes ☐ No

Health Maintenance: Date of last colonoscopy: ________ Date of last Eye Exam: _______ Date of last EKG: _________
Date of last Dental Exam: __________ **Women Only**: Last menstrual period? ________ Date of last pap: __________
Date of last Mammogram: _________ Are you currently pregnant? ☐ Yes ☐ No

Past Medical History: Please mark all that apply.

☐ Allergies	☐ Blood clots	☐ Gallbladder disease	☐ MI (heart attack)
☐ Anemia	☐ Cancer Type:_______	☐ GERD	☐ Osteoarthritis
☐ Angina	☐ CVA (stroke)	☐ Hepatitis C	☐ Osteoporosis
☐ Anxiety	☐ COPD	☐ High Cholesterol	☐ Peptic Ulcer disease
☐ Arthritis	☐ Coronary Art. disease	☐ High blood pressure	☐ Renal disease
☐ Asthma	☐ Crohn's Disease	☐ Irritable bowel syndrome	☐ Seizure disorder
☐ Atrial Fibrillation	☐ Depression	☐ Liver Disease	☐ Thyroid disease
☐ Benign prostatic hypertrophy	☐ Diabetes	☐ Migraine headaches	☐ Other __________

Past Surgical History:

	Year:		Year:
☐ Angioplasty	________	☐ Small Bowel Resection	________
☐ Angio w/stent	________	☐ Thyroidectomy	________
☐ Appendectomy	________	☐ Tonsillectomy	________
☐ Arthroscopy knee	________	**FEMALES ONLY:**	
☐ Back surgery	________	☐ Breast augmentation	________
☐ CABG	________	☐ Tubal Ligation	________
☐ Carpal Tunnel	________	☐ Breast Biopsy	________
☐ Cataract extraction	________	☐ C-Section	________
☐ Cholecystectomy (gall bladder)	________	☐ D and C	________
☐ Colectomy	________	☐ Hysterectomy	________
☐ Colostomy	________	☐ Mastectomy	________
☐ Gastric Bypass	________	☐ Myomectomy	________
☐ Hernia Repair	________	☐ Breast reduction	________
☐ Hip replacement	________	☐ TAH/BSO	________
☐ Knee replacement	________	☐ Vaginal Hysterectomy	________
☐ LASIK	________	**MALES ONLY:**	
☐ Liver biopsy	________	☐ Prostate biopsy	________
☐ ORIF	________	☐ TURP	________
☐ Pacemaker	________	☐ Vasectomy	________

Family History of (mark all that apply and indicate for Mother, Father, Siblings):

☐ ADD/ADHD ________	☐ CVA (stroke) ________	☐ Learning Disability ______	☐ Other __________
☐ Alcoholism ________	☐ Depression ________	☐ Mental Illness ______	
☐ Allergies ________	☐ Developmental delay _____	☐ Migraines ______	**Age/cause of death of:**
☐ Alzheimer's disease ______	☐ Diabetes ________	☐ Obesity ______	Mother: ☐ n/a __________
☐ Asthma ________	☐ Eczema ________	☐ Osteoarthritis ______	Father: ☐ n/a __________
☐ Blood disease ________	☐ Hearing Deficiency ______	☐ Osteoporosis ______	Siblings:☐ n/a __________
☐ CAD ________	☐ High Cholesterol ______	☐ Periphereal Vascular disease	
☐ Cancer: Type ________	☐ High blood pressure ______	☐ Renal disease ______	
	☐ Irritable bowel syndrome ___	☐ Seizure disorder ______	

Social History:

Marital Status:
☐ Married ☐ Single
☐ Divorced ☐ Widowed

Alcohol Consumption:
☐ No ☐ Yes ☐ Formerly
Type: ______ Frequency: _____
Amount: _______

Caffeine:
☐ No ☐ Yes Type: __________
Caffeine per day: __________

Reviewed by: __________

Date: ______________

Living Arrangements:
☐ Alone ☐ Family/Sig.Other
☐ Other ☐Asst. Living
☐ Daily help needed for self-care
Name of Caregiver:______________

Abuse / Neglect: Adults only
Are you experiencing neglect and/or conflict in your family and/or relationships?☐Yes ☐No
Explain: ______________
____

Activities of Daily Living:
Any difficulty with?
☐ Speech/Communication
☐ Memory
☐ Bathing
☐ Household Duties

\# of Children: ___________

Street Drug Use? ☐ Yes ☐ No
Type: ______________
Started: ____________
Quit: ______________

Learning Needs:
Are there any needs (learning, ethnic, cultural, or spiritual) we should know about that might impact your care or your ability to understand treatments / procedures/ educational materials?
☐ Yes ☐ No
Please explain: __________
____
____

PROTECTED HEALTH INFORMATION RELEASE: PATIENTS 18 YEARS AND OLDER

Please check all applicable boxes and fill in any blank spaces where information is requested.

☐ Only release information to me personally.

☐ You have my permission to speak with my Spouse/Significant Other about my medical care and test results.
Spouse/Significant Other's Name ______________________________ Phone ________________

☐ You have my permission to talk with my children or other family members involved with my medical care.
Name ____ Phone ________________
Relationship ____
Name ____ Phone ________________
Relationship ____
Name ____ Phone ________________
Relationship ____
Name ____ Phone ________________
Relationship ____

☐ You have my permission to leave information on my answering machine regarding my medical care and test results.

☐ Other, please describe: ____

Emergency Contact:

Last Name ________________________ First Name _____________ Phone Number ___________
Address __________________________ City __________________ State _______ Zip ________
Relationship to Patient ____

Patient Contact:

Patient Email ____
Phone (Home) ____________________________ Phone (Cell) _____________________________
Phone (Work) ________________ Preferred Message/Contact Phone: ☐ Home ☐ Cell ☐ Work

_________________________________ _____________________ _____________________
Patient Signature Date Time

People assisting with paperwork:

_________________________________ __________________________ _______________
Interpreter's name Interpreter's Signature and/or ID # Date and Time

_________________________________ __________________________ _______________
Office Staff's name Office Staff Signature Date and Time

Place patient sticker here or handwrite

Name ______________________________

DOB: ______________________________

Insurance/HIPAA E3
Rev 05-02-2011
Form 0003

HAVE PATIENT/GUARDIAN DATE AND INITIAL:

Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials

Saint Alphonsus Medical Group

Financial Policy

We will file your insurance claims for you. We do request a copy of your current insurance card to ensure accurate billing. Please keep in mind we do not accept all insurances. If you do not have insurance or if your insurance does not cover the services you need from our clinic, payment is your responsibility. It is also your responsibility to confirm directly with your insurance company to find out whether or not we participate with them, and if they will cover the medical services being provided to you. If your insurance requires a referral, co-pay, deductible, or coinsurance, it is your responsibility to have it with you at the time of service. Failure to do so may result in us having to reschedule your appointment.

- **Medicaid Patients**: You must have a valid Medicaid card, presumptive eligibility, or letter/printout from your caseworker at every visit. We also require photo ID, which will be scanned into our computer system. Lack of this information may result in us having to reschedule your appointment.

- **Minors**: The parent/guardian accompanying the minor at the time of service is responsible for payment.

- We will request payment at the time of service. If this is not possible, we will expect you to make acceptable payment arrangements, prior to receiving service.

- You will receive at least two statements after to your visit at our clinic. If your account is not paid in full, or if you have not established an acceptable payment plan, we will refer your account to a professional credit bureau.

- The credit bureau will send you a notification that a payment is due. The letter will arrive at your last known address. You must respond to this letter, to avoid damage to your credit record. If you do not respond to this letter, your account will be listed for collection and your credit will be adversely affected.

- I understand and agree that if I fail to pay for services for which I am responsible, after such default and upon referral to a collection agency by Saint Alphonsus Medical Group, I will be responsible for all cost of collecting monies owed, including court costs, and collection agency fees.

We are disclosing our policy to you now to avoid misunderstanding in the future.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND/OR MEDICAL RECORDS

Patient Name ____ **Date of Birth** _______________

(Please print)

I authorize ("the Clinic") to use or disclose Protected Health Information ("PHI") contained in my medical records in the following manner:

From: ____

Physician/Institution that presently has data

____

Street Address

____

City State Zip Phone Fax

To: ____

Physician/Institution requesting data

____

Street Address

____

City State Zip Phone Fax

Release the following Protected Health Information:

____ All Records _____ Chart Notes _____ X-Rays _____ Labs _____ Substance Abuse Info _____Mental Health _____ HIV

______ Other (please specify): ____

(Describe the information to be used or disclosed, including date of service, type of service, level of detail to be released or specific information) Transfer of care____

The Protected Health Information is being used or disclosed for the following purpose(s): [If the patient is requesting the release, this may state "at patient's request"]

____

(List specific purposes the Protected Health Information will be utilized)

_______ Please FAX requested information to the fax number listed above.

(Maximum of 10 pages may be faxed, if request is more, records will be sent to the address indicated above.)

This authorization is in full force and effect until _______________ (Date) or until _____________________ (List specific event)

If I fail to specify an expiration date/event, this authorization will expire in twenty-four (24) months.

I understand that I have the right to revoke this authorization in writing by sending notification to:

CLINIC NAME:

ATTN: Privacy Officer

ADDRESS:

I understand that when I revoke this authorization, it is not effective to the extent that the Clinic has already relied on the use or disclosure of the Protected Health Information. I understand the Protected Health Information released pursuant to this authorization might be re-disclosed by the party who receives that information and may no longer be protected by federal or state law. The Clinic will not base my treatment or payment on whether I provide an authorization for the requested use or disclosure, unless the provision of health care is solely for the purpose of creating Protected Health Information for disclosure to a third-party (such as fitness for work exam). I understand that I have a right to inspect or copy the protected health information to be used or disclosed. I understand that I have a right to refuse to sign this authorization. If you have any questions concerning this form, please phone: (-   )

SPECIFIC AUTHORIZATION: I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have crossed it out and initialed. YES_______ NO________ (initials)

____ _______________

Patient Signature Date and Time

____________________________ ____________________ _______________

Legal Representative Name/Relationship to patient Legal Representative Signature Date and Time

People assisting with paperwork:

____________________________ ____________________ _______________

Interpreter's name Interpreter's Signature and/or ID # Date and Time

____________________________ ____________________ _______________

Office Staff name Office Staff Signature Date and Time

Place patient sticker here or handwrite

Name: ________________________

DOB: _________________________

Saint Alphonsus Medical Group

Complete both sides

DETERMINATION OF MEDICARE AS PRIMARY OR SECONDARY PAYOR RESPONSIBILITY

As part of participation in the Medicare program it is necessary for beneficiaries (patients) seeking services to identify certain items relative to insurance issues that will allow Medicare to determine primary or secondary coverage. Therefore, please answer the following questions.

1) Are you currently working full or part time? Yes _____ No _____ [12]

2) If you are married, is your spouse working full or part time? Yes _____ No _____ [12]

3) If YES to any of the above, are you covered under an employer group health plan based on your or your spouse's current employment? Yes _____ No _____ [12]

4) If YES to (3) above, please provide the following information:

____
Name of the insured and relationship to the Medicare Beneficiary

____
Name and address of employer

____
Name and address of the group insurance carrier

____
Policy number

____
Group identification number

5) Are you entitled to Black Lung medical benefits? Yes _____ No _____ [41]

6) Is this service for treatment of a work related injury? Yes _____ No _____ [15]

____
If YES please provide the name and address of your employer and workers compensation carrier

Place patient sticker here or handwrite

Name: ______________________________

DOB: _______________________________

DETERMINATION OF MEDICARE AS

PRIMARY OR SECONDARY PAYOR RESPONSIBILITY, CONT'D

7) Is this service for treatment of an illness or injury which resulted from an automobile accident [47] or other accident [14]? Yes _____ No _____ If Yes, which one?

   ____

   If YES please provide the name and address of your liability insurance carrier
8) Are the services to be paid by a government program such VA benefits [42], Disability [43] or a research grant [16]?
   Yes _____ No _____ If Yes, Which one? ____________________________
9) Are you entitled to Medicare based on ESRD (End Stage Renal Disease)?
   Yes _____ No _____ [13]
   (If yes please complete additional form)

Statement to permit payment of clinic and medical insurance benefits to Saint Alphonsus Medical Group

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made in my behalf.

I assign payment for the unpaid charges of the physician(s), and other authorized care providers, to be billed in connection with its services. I understand I am responsible for any insurance deductibles and/or twenty percent of the remaining allowable charges.

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by Saint Alphonsus Medical Group including physician services. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

______________________	______________________	______________
Patient Name	Patient Signature	Date/Time

The Patient is unable to sign because ____,

I therefore sign and agree to the other provisions of this form as the Patient's authorized legal representative.

______________________	______________________	______________
Legal Representative Name/Relationship to patient	Legal Representative Signature	Date and Time
Interpreter's name	Interpreter's Signature and/or ID #	Date and Time
Office Staff Name	Office Staff Signature	Date and Time

Place patient sticker here or handwrite

Name: ____________________________

DOB: _____________________________