Caldwell Family Clinic
Registration Form

Date:_____ Pharmacy:_____

Patient Information

Patient Name:_____ Age:_____ Sex:_____
First MI Last

Mailing Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

May we leave a message on your: Home Phone: ☐ Yes ☐ No Cell Phone: ☐ Yes ☐ No

Employed by: _____ Work Phone: _____

DOB: _____ SSN:_____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

E-mail Address:_____ Race_____

Are you Hispanic/Latino? ☐ Yes ☐ No Primary language used at home:_____

Person Responsible for Bill (if patient is under age 18)

Name:_____ SSN:_____
First MI Last

Mailing Address:_____

City:_____ State:_____ Zip:_____

Work Phone:_____ Cell Phone:_____

MEDICAL INSURANCE INFORMATION - PRIMARY INSURANCE

We cannot file insurance without a copy of your photo ID and insurance cards for verification of coverage.

Insurance Company:_____	State:_____ Zip:_____
Policy #:_____	Home Phone:_____
Group #:_____	Cell Phone:_____
Group Name:_____	Date of Birth:_____
Name of Policyholder:_____	SSN:_____
Address:_____	Employer:_____
City:_____	Work Phone:_____

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MEDICAL INSURANCE INFORMATION - SECONDARY INSURANCE
We cannot file insurance without a copy of your photo ID and insurance cards for verification of coverage.

Insurance Company:_____	State:_____ Zip:_____
Policy #:_____	Home Phone:_____
Group #:_____	Cell Phone:_____
Group Name:_____	Date of Birth:_____
Name of Policyholder:_____	SSN:_____
Address:_____	Employer:_____
City:_____	Work Phone:_____

Advanced Directive Information

I have an Advanced Directive: ☐ Yes ☐ No (if yes, please provide us with a copy for our records.)

If no, would you be interested in received information on an Advance Directive? ☐ Yes ☐ No

PATIENT CONSENT FOR TREATMENT: The undersigned agrees that all records concerning this patient's hospitalization or treatments shall remain the property of the Hospital and Clinic. The undersigned understands that medical records and billing information generated or maintained by the Hospital and Clinic are accessible to hospital, clinic personnel, and medical staff. Hospital, clinic personnel and medical staff may use and disclose medical information for treatment, payments, and healthcare operations and to any other physician, healthcare personnel or provider that is or may be involved in the continuum of care for this admission or outpatient treatments. The Hospital and Clinic is authorized to disclose all or part of the patient's medical records to any insurance company, third party payor, worker's compensation carrier, self-insured employer group or other entity (or their authorized representatives) which are necessary for payment of the patient's account. State law requires that the Hospital and Clinic advise the undersigned that THE INFORMATION RELEASED MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE REQUIRES TO BE REPORTED UNDER STATE LAW. The Hospital and Clinic are authorized to disclose all or any portion of the patient's medical record as set forth in its Notice of Privacy Practices, unless the patient objects in writing. By signing this form, you are authorizing such disclosures. I have been notified that I may receive services from the Nurse Practitioner or Physician Assistant at this location.

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

_____ Date:_____

Patient or Authorized Person's Signature

Caldwell Family Clinic

Medical and Personal History

Patient Name:_____ Date:_____

DOB:_____ Sex:◯/◯ Race:_____

Doctor's Notes: _____

_____

Please indicate when you last had any of the following preventative tests or services:

Year	Year	Year	Year
____ Cardiac Angiogram	____ Flu Vaccine	____ Prostate Cancer Blood Test	____ Stomach Surgery
____ Stress Test	____ Pneumonia Vaccine	____ Rectal Exam	____ Inguinal Hernia
____ Electrocardiogram	____ Tetanus Vaccine	____ Colon Cancer Stool Test	____ Colonoscopy
____ Chest X-ray	____ Hepatitis Vaccine	____ Flexible Sigmoidoscopy	____ Gallbladder
____ EKG	____ Bone Density Test	____ Barium Enema	____ Appendectomy
			____ Prostate Surgery
			____ Bladder Surgery

Doctor's Notes: _____

_____

Please List any allergies or intolerance to drugs or other substances: _____

_____

Please list medications currently taken, their dosages, and how many times per day you take them:

_____ _____

_____ _____

_____ _____

FAMILY MEDICAL HISTORY

Please check or list any major illness in your family members. (Mother, Father, Brother, Sisters, or Children.)

◯ Tuberculosis	◯ Diabetes Mellitus	◯ Kidney Disease	◯ Breast Cancer
◯ Emphysema	◯ Thyroid Disease	◯ Epilepsy	◯ Ovarian Cancer
◯ Heart Disease	◯ Anemia	◯ Neurological Disease	◯ Colon Cancer
◯ High Blood Pressure	◯ Hemophilia	◯ Liver Disease	◯ Prostate Cancer
◯ Osteoporosis	◯ _____	◯ _____	◯ _____

Notes: _____

_____

Caldwell Family Clinic

Medical and Personal History

Patient Name:_____ Date:_____

DOB:_____ Sex: M / F Race:_____

For what reason are you here today? _____

_____

_____

Please check conditions which you have had:

General
- ○ Serious Infections
- ○ Diabetes Mellitus
- ○ Rheumatic Fever
- ○ HIV Infection
- ○ Cancer (where?)_____

CVS
- ○ High Blood Pressure
- ○ Congestive Heart Failure
- ○ Heart Murmur
- ○ Heart Valve Disease
- ○ Angina
- ○ Heart Attack
- ○ High Cholesterol
- ○ Abnormal Heart Rhythm
- ○ Blood Clots in Veins
- ○ Blocked Arteries in Neck
- ○ Blocked Arteries in Legs

HEENT
- ○ Glaucoma
- ○ Allergies "hay fever"
- ○ Frequent Ear Infections
- ○ Frequent Sinus Infections

RESPIRATORY
- ○ Asthma
- ○ Emphysema
- ○ Blood Clots in Lungs
- ○ Sleep Apnea

MUSCULOSKELETAL/ESTREMITIES
- ○ Osteoporosis
- ○ Rheumatoid
- ○ Degenerative Joint Disease
- ○ Fibromyalgia
- ○ Neck Pain (herniated disc)
- ○ Back Pain (herniated disc)

LYMPHATIC / HEMATOLOGIC
- ○ Thyroid Fever
- ○ Over Active Thyroid
- ○ Under Active Thyroid
- ○ Transfusion
- ○ Anemia

GI / GU
- ○ Stomach Ulcers
- ○ Ulcerative
- ○ Crohns Disease
- ○ Bleeding from Intestines
- ○ Diverticulitis
- ○ Colon Polyps
- ○ Irritable Bowel Disease
- ○ Hepatitis
- ○ Cirrhosis of the Liver
- ○ Liver Failure
- ○ Pancreatitis
- ○ Gallstones
- ○ Kidney Stones
- ○ Kidney Failure
- ○ Prostate Disease
- ○ Endometriosis
- ○ Sex Transmitted Infection

SKIN/BREAST
- ○ Acne
- ○ Eczema
- ○ Psoriasis
- ○ Fibrocystic Breast Disease

NEUROLOGIC/PSYCHIATRIC
- ○ Chronic Vertigo (Meniere's)
- ○ Peripheral
- ○ Migraine Headaches
- ○ Stroke
- ○ Multiple Sclerosis
- ○ Depression
- ○ Anxiety

Doctor's Notes: _____

_____

Please indicate any surgeries you have had and the year you had them:

Year
- ☐ Angioplasty
- ☐ Carotid Artery Surgery
- ☐ Other Vascular Surgery
- ☐ Coronary Bypass Surgery
- ☐ Chest / Lung Surgery
- ☐ Tonsillectomy
- ☐ Neurosurgery

Year
- ☐ Trauma Related Surgery
- ☐ Back or Neck Surgery
- ☐ Hip Surgery
- ☐ Knee Surgery
- ☐ Carpal Tunnel Surgery
- ☐ Sinus Surgery
- ☐ Ear Surgery

Year
- ☐ Stomach Surgery
- ☐ Inguinal Hernia
- ☐ Colonoscopy
- ☐ Gallbladder
- ☐ Appendectomy
- ☐ Prostate Surgery
- ☐ Bladder Surgery

Year
- ☐ Tubal Ligation
- ☐ C-Section
- ☐ Hysterectomy
- ☐ Ovary Removed
- ☐ Breast Surgery
- ☐ Thyroid
- ☐ Other

Caldwell Family Clinic

Medical and Personal History

Patient Name:_____ Date:_____

DOB:_____ Sex: M / F Race:_____

PERSONAL INFORMATION

Please write in or circle the information that applies to you:

Occupation:

Education
- Primary
- Secondary
- College
- Post grad
- Doctorate

Sexuality
- Heterosexual
- Homosexual
- Bisexual
- Transsexual

Marital Status
- Single
- Married
- Divorced
- Widowed
- Separated

Living Status
- Alone
- With Spouse
- With Parents
- Assisted Living
- Nursing Home

Diet
- None
- Low Fat
- Low Chol
- Low Carb
- Vegetarian

Exercise
- None
- Walking
- Aerobics
- Weightlifting

___days/wk

Alternative Medicine
- None

Tobacco

☐Never ☐Past ☐Active

☐Cigarette ☐cigar ☐pipe

☐Snuff ☐dip ☐chewing

Start____ Stop_____

Packs per day_____

Alcohol

☐Never ☐ Past ☐Active

☐liquor ☐wine ☐ beer

___drinks per

☐Day ☐week ☐month

☐AA ☐Alcohol Rehab

Illicit Drugs

☐Never ☐Past ☐Active

☐Cocaine ☐marijuana

☐Heroin ☐amphetamine

☐Barbiturate ☐LSD ☐PCP

☐IV Drug Abuse ☐Drug Rehab

Caffeine

☐Never ☐Past ☐Active

☐Coffee ☐tea ☐soda

___cans / cups per day

Doctor's Notes: _____

_____

Caldwell Family Clininc
Caldwell, KS

Disclosure of Protected Health Information

I *authorize* Caldwell Family Clinic to communicate with the following individuals about my medical condition, diagnosis, treatment, appointments (past and future), and financial obligation. I understand medical information may be withheld from individuals, including family members, unless I list them by name below:

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

I authorize Caldwell Family Clinic to leave voicemail and answering machine messages regardings test results or other healthcare related concerns at my home or cell phone number. Please circle one: ◯ Yes ◯ No

Emergency Contact

Emergency Contact:_____ **Relationship:**_____

Phone Number:_____

PATNAME
DOB - PATBDAY
MR # PATMRNUM
Account Number PATNUM
Admit Date: PATADMIT

SUMNER COUNTY HOSPITAL DISTRICT NO 1 AND CALDWELL FAMILY CLINIC
AUTHORIZATION FOR EMERGENCY TREATMENT

1. The undersigned has been informed of the emergency treatment considered necessary for the patient whose name appears on the reverse hereof and that the treatment and procedures will be performed by physicians, members of the house staff and employees of the hospital. Authorization is hereby granted for such treatment and procedures.

2. MEDICARE - MEDICAID PATIENT'S CERTIFICATION: Authorization to release information and payment request. I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.

3. ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to Sumner County Hospital District No 1 and Caldwell Family Clinic benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, including major medical, directly to the attending physician but not to exceed regular charges for these services. I understand that I am financially responsible to the hospital and physician for charges not covered by this assignment.

4. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: The hospital and clinic attending physician are authorized to furnish any medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment for my care.

5. REFUND OF INSURANCE BENEFITS: I authorize the refund of overpaid insurance benefits in accordance with my insurance policy conditions where my coverages are subject to a coordination of benefits clause.

6. I understand that health care services paid under Medicare, Medicaid, and maternal and child health programs are subject to review by the Professional Standards Review Organization.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, contact the federal surprise billing hotline at 1-800-985-3059.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

I acknowledge I have received a copy of Sumner County Hospital District No 1's Notice of Privacy Practices.

Date PATADMIT Patient

Please email completed form to: clinicregistration@schd1.com

Date PATADMIT Witness

Responsible Party Relationship to Patient