MERCYHEALTH
Physicians

PATIENT REGISTRATION FORM

First Name_____ MI_____Last Name_____Date of Birth _____

Address _____ City_____State _____ZIP_____

Home Phone (___)_____Cell Phone (____) _____Work Phone (___)_____

SS#_____-_____-_____ Sex: **M F** Email Address:_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race: ☐ American Indian and Alaska Native ☐ Bi-Racial ☐ Middle Eastern ☐ Hawaiian/Pacific Islander
☐ Black or African American ☐ White/Caucasian ☐ Other ☐ Unknown

Employed: **Y / N PT / FT** Employer:_____ Address:_____

Marital Status: **M S D W Sep SO** Spouse Name_____Spouse DOB _____

How did you hear about us?_____

Advance Directives: Do you have a Living Will? ☐ Yes ☐ No Preferred Language _____

Emergency Contact: Name_____Relationship_____ Phone (____) _____

If the Patient is **NOT the** Subscriber (person who carries insurance) please provide additional information requested below:

Primary Insurance:_____Subscriber Name:_____Relationship:_____

DOB: _____Employed: **Y / N PT / FT** Subscriber Name of Employer:_____

Secondary Insurance: _____Subscriber Name:_____Relationship: _____

DOB: _____Employed: **Y / N PT / FT** Subscriber Name of Employer: _____

If you have MEDICARE, please also complete the questions on the bottom of this form

Primary Care Physician:_____Address:_____Phone:(____) _____

Referring Physician: (if applicable)_____ Phone (____) _____

If you have Medicare, please answer the following questions:

1.	Are you receiving Black Lung benefits?	Yes	No
2.	Are the services to be paid by a government research program?	Yes	No
3.	Are you entitled to benefits through the Department of Veterans Affairs?	Yes	No
4.	Was the illness/injury due to a work-related accident/condition?	Yes	No
5.	Are you entitled to Medicare based on Age?	Yes	No
6.	Are you entitled to Medicare based on Disability?	Yes	No
7.	Are you entitled to Medicare based on End Stage Renal Disease (ESRD)?	Yes	No

NOTICE: I attest that the above information is correct to the best of my knowledge. I authorize the release of any medical or other information necessary to process the claim. I also request payment of insurance benefits either to myself or to the party who accept assignment. I authorize payment of insurance benefits to the physician or supplier for all services rendered. I also understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered or fees associated with my care. I also agree that I am responsible for any collection fees should my account be turned over to a collection agency.

_____ _____
Signature of Person Responsible Date

MERCYHEALTH
Physicians

Patient Name_____

DOB: _____

Physician Office Consent for Treatment, Payment, and Health Care Operations

This consent cannot be modified. Any handwritten changes to the form shall not be legally binding or enforceable.

I. Consent to Medical Care & Treatment

1. I am seeking medical care and treatment at Mercy Health. I consent to the rendering of such medical care and treatment as is deemed necessary by my provider, other members of the medical staff and by Mercy Health and its employees. I also understand that there are risks of injury from medical care and treatment of my medical condition.

II. Notice of Legal Relationship between Physician Office & Independent Medical Practitioners

1. I understand and acknowledge that Mercy Health facilities allow providers who are not employed, directed, or controlled by Mercy Health to practice at Mercy Health facilities and that these providers may render professional services to me while I am in a Mercy Health facility. Mercy Health is not responsible for the acts or omissions of any independent contractor.
2. For combined services, you may receive multiple bills – some services may include facility charges as well as professional fee billing. I understand that the level of insurance benefits payable for treatment by my provider(s) may be different from the level of insurance benefits payable for treatment by the hospital.

III. Responsibility for Payment

1. I agree to accept full responsibility for payment of all charges related to my care. I understand that a list of common charges is available to me upon request.
2. I understand that I am responsible for any amounts not paid by my health insurance or any other insurance plan or policy, including but not limited to, any deductibles, copays, and coinsurance amounts provided under any coverage source, and charges for which there is no coverage source.
3. If I choose to pay for certain services out of pocket and exercise my right to limit disclosure of my medical information to my health insurance plan regarding those services, I understand that a separate financial arrangement will be put into place regarding the self-pay services and Section IV below will not apply.

IV. Financial Agreements / Assignment of Benefits / Authorized Representative / Agent

1. I assign to Mercy Health all rights to benefits, insurance payments, insurance reimbursements, or other payments or judgments to which I may be entitled for services provided to me at Mercy Health facilities. I authorize Mercy Health to bill my insurance and assign the payment of these benefits directly to Mercy Health.
2. I authorize, designate and convey to Mercy Health, as my authorized agent and representative to the fullest extent permissible under law, under any applicable insurance policy, group health plan, employee benefits plan, health insurance plan with the power to: (i) act on my behalf with respect to all matters related to all of my rights, benefits, privileges, protections, claims, causes of action, interests or recovery arising out of any coverage source, including but not limited to the ability to request reconsideration and/or appeal payment decisions made by the plan, or utilization review entity for coverage or grievance review; and (ii) the right and ability to act on my behalf to pursue such claim, claims, causes of action, interests or recovery with respect to the plan (including, but not limited to, the right to act on my behalf with respect to a plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.503-1(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Mercy Health. This includes, without limitation, the authority and right to: file medical claims, appeals, and grievances

Patient/Guardian/Legal Rep Initials [_____]

with the plan; request verification of coverage or pre-certification or authorization; file pre-service and post-service claims; request any and all information and documents under which the plan is established or operated; request any and all policies, procedures and guidelines and protocols considered by the plan in connection with the benefit claim determination; and to institute any litigation and/or complaints against the plan naming me as the plaintiff in such litigation if necessary. I understand I can revoke this authorization in writing at any time.

3. I authorize Mercy Health to release my medical information (including medical information in my Mercy Health record relating to services provided to me by third parties) or other information, if required to obtain payment from my insurance or other payer and their agents to process payments, or to government agencies or their designees for review of the care provided to me, in accordance with applicable law.
4. Your treating provider may order services or items that require upfront approval from your insurance company before you receive the services or items. I agree to cooperate, aid and assist Mercy Health in obtaining all possible insurance benefits for such services or items (for example: completing an application for insurance, providing timely information as requested).
5. If I make an application for Financial Assistance according to Mercy Health internal policies, Mercy Health is permitted to provide information as necessary to determine whether I am eligible for Financial Assistance.

V. Medicare, Medicaid & Other Insurance Certification

1. I certify that the information given by me in applying for payment under the Medicare Program of Title XVIII of the Social Security Act or Medicaid Program is correct. I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services or its intermediaries/carriers or any commercial insurance carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf.

VI. Communication to Patients

1. I consent to receive communications related to my current and/or prospective medical care at the following telephone number(s) and/or email address: (__) - _____ (home phone #) / (__) - _____ (mobile phone #) / _____ (email). These communications (a) may use live or artificial/prerecorded voices, automatic telephone dialing systems, text messages, or other computer-aided technologies and (b) may come from Mercy Health, its affiliates, clinical providers, physicians, business associates, billing/collection services or third parties acting on Mercy Health's behalf. Message and data rates may apply. I may revoke this consent at any time and my consent is not required to receive medical care.

   I consent [initials: ____] I do not consent [initials: ____]

2. I consent to receive communications about my account and/or general communications regarding Mercy Health services, promotions, activities, and programs at the following telephone number(s) and/or email address: (__) - _____ (home phone #) / (__) - _____ (mobile phone #) / _____ (email). These communications (a) may use live or artificial/prerecorded voices, automatic telephone dialing systems, text messages, or other computer-aided technologies and (b) may come from Mercy Health, its affiliates, clinical providers, physicians, business associates, billing/collection services or third parties acting on Mercy Health's behalf. Message and data rates may apply. I may revoke this consent at any time and my consent is not required to receive medical care.

   I consent [initials: ____] I do not consent [initials: ____]

MERCYHEALTH
Physicians

Patient Name_____

DOB: _____

VII. Patient Agreement

I have read this Consent for Treatment, Payment and Health Care Operations form or have had it read to me, and it has been explained to my satisfaction.

By signing this document, I confirm that I accept the terms of this document, and confirm that any questions have been asked and answered. I further certify that I am the patient or his/her duly authorized representative, and that I am signing voluntarily.

Print: _____ Relationship: _____Initials: ____ Date/Time: _____
Patient or Legal Guardian or Patient Representative

Signature: _____ Relationship: _____Initials: ____ Date/Time: _____
Patient or Legal Guardian or Patient Representative

Print: _____ Date: _____
Witness

Signature: _____ Date: _____
Witness

Legal Guardian signed because: [___] Patient is a minor [___] A Guardianship has been established

Patient is unable to sign because: _____

MERCYHEALTH
Physicians

Patient _____
DOB _____

Communication Release of Information

The Privacy Rule generally requires healthcare providers to take reasonable steps to minimize the Protected Health Information (PHI) requests, usage and disclosure for only what is required to meet the intended need. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

NOTE: Uses and disclosures for reasons other than treatment, payment, or operations may be permitted without prior consent in a medical emergency.

_____ DO NOT PROVIDE health information (regarding blood work, appointments, and test results) to anyone but me.

_____ I give permission to receive my health information regarding normal test results in a voice mail message.

Authorized Representatives

I give permission for the following people to receive the following PHI elements as specified below.

Name_____Relationship_____DOB_____

Contact Telephone #_____

___ Appointments ___Billing ___Test Results____Discuss my condition and treatment

Name_____Relationship_____DOB_____

Contact Telephone #_____

___ Appointments ___Billing ___Test Results____Discuss my condition and treatment

Name_____Relationship_____DOB_____

Contact Telephone #_____

___ Appointments ___Billing ___Test Results____Discuss my condition and treatment

Name_____Relationship_____DOB_____

Contact Telephone #_____

___ Appointments ___Billing ___Test Results____Discuss my condition and treatment

My signature below acknowledges that I provided the information above.

Signature of Patient/Legal Guardian_____**Date** _____

MERCYHEALTH

OFFICE USE ONLY
Acct/MRN
Initials
Pages
Date

PATIENT REQUEST TO ACCESS OR COPY HEALTH INFORMATION

Complete all sections entirely. If this request is not complete, it may be returned and result in delay in processing. Photo ID required at the time of request and pick up.

Patient name:	**Date of Birth:**	**Last 4 digits of SS#:**	**Telephone #:**

Address: _____
Street City State Zip Code

Mercy Health Hospital or Physician office health information requested from: (Check all that apply)

☐ Anderson ☐ Clermont ☐ Fairfield ☐ The Jewish Hosptial ☐ Westside (Mt. Airy and Western Hills)

☐ Springfield Regional Medical Center ☐ Mercy Memorial Hospital

☐ Physician/Practice Name:_____ ☐ Other Healthcare Provider:_____

Dates of service to release: (from):_____(to):_____

Specific reports to be disclosed: (Check all that apply)

☐ Abstract of record (Discharge Summary, H&P, Operative Report, Consults, Test results....) ☐ Office Visit

☐ Emergency Department record ☐ History & Physical ☐ Operative report ☐ Discharge Summary

☐ Immunization record ☐ Test results (Lab, Pathology, Radiology, and Cardiac)

☐ Other (Images, Photos): _____

☐ Entire record (standard two years of information, unless otherwise specified): _____

If pick up or mailing records, format selected: ☐ Paper ☐ Electronic (CD)

Information to be disclosed via: (Check one)

Name of requestor (if different): _____

☐ Mail to address above

☐ Fax to number:_____(page limitation may apply)

☐ Email to:_____(I acknowledge and accept the risks associated with unsecure transmission and Mercy Health is not liable for disclosures that occur in transit. I acknowledge file size limitations. If file cannot be sent by email due to file size, I will provide mailing address or will pick information up)

☐ Pick up location/site: _____

- I understand and acknowledge there is no charge to access (read/review) my health information or to provide me with a copy of specific reports/tests/abstract. (by appointment 24/48 hour notice required) If I request my entire record of health information, there will be a fee. Health information maintained in electronic format and provided in electronic or paper media will be $6.50 flat fee. Health information maintained in paper format will $0.10 per page.
- I understand and acknowledge if I am requesting my health information while I am In House/Admitted or receiving on-going services, my record may not be complete and I will need to request after services are completed and finalized

_____ _____
Signature of Patient/Patient's Legal Representative Date

Relationship to patient:_____*(Supporting documentation of authority must be provided)*

Witness (optional):_____

MERCYHEALTH

Name:_____ Today's Date:_____

Sex:_____ Age:_____ Height:_____ft._____in. Weight:_____lbs.

Recent weight change? Are you?
□ gain □ loss □none □right-handed □ left-handed

What problem are you being treated for today?_____

Have you been treated by another physician for this problem? □ yes □ no Who?_____

Were x-rays taken? □ yes □ no Where were x-rays done?_____ When?_____

Past Medical History

Medical Illnesses (*check any illness that you currently have or have had in the past.)*

□ arthritis	□ diabetes	□ neuropathy	□ ulcer disease
□ asthma	□ glaucoma	□ rheumatoid disease	□ vascular disease
□ bleeding disorder	□ heart disease	□ seizure	□ others
□ blood clots	□ hepatitis	□ stroke	_____
□ cancer	□ high blood pressure	□ substance abuse	_____
□ cataract	□ kidney/bladder problem	□ thyroid	_____

Past Surgeries (*check any illness that you currently have or have had in the past)*

_____ _____

_____ _____

Your Allergies to Medications (*name medication and reaction)* _____

Your Current Medication *(name of medication, dose and how often)*

_____ _____ _____

_____ _____ _____

Family History

Mother: □ living □ deceased Age (*now or at death)*_____ Cause of death:_____

Father: □ living □ deceased Age (*now or at death)*_____ Cause of death:_____

Has any blood relative had any of the following (*please check and indicate relationship, i.e. mother, father, etc.)*

□ anesthesia problem	□ cancer	□ kidney disease	□ other
□ arthritis	□ diabetes	□ seizures	_____
□ asthma	□ heart disease	□ stroke	_____
□ bleeding disorder	□ high blood pressure	□ tuberculosis	_____

Social History

□ single □ married □ widowed □ separated □ divorced #of children:_____ and their present health status:_____

Your present occupation:_____

Do you drink alcohol? □ yes □ no Do you smoke? □ yes □ no Packs per day:_____years:_____

Do you use recreational drugs? □ yes □ no

Patient Signature:_____ **Date**:_____

MERCYHEALTH

Name:_____ **Date:**_____

REVIEW OF SYSTEMS	ARE YOU **CURRENTLY** EXPERIENCING ANY OF THE FOLLOWING CONDITIONS *(Circle Yes or No)*		If any yes answer, please explain below
General	Recent weight change	No / Yes	
Skin	Skin condition / cancer	No / Yes	
Head, eyes, ears, nose & throat (ENT)	Headaches	No / Yes	
	Dizziness / blacking out	No / Yes	
	Eye or hearing impairment	No / Yes	
	Sinus or throat trouble	No / Yes	
	Nosebleeds	No / Yes	
Neck	Thyroid disease	No / Yes	
	Enlarged glands	No / Yes	
Respiratory	Asthma	No / Yes	
	Difficulty breathing	No / Yes	
	Pleurisy or pneumonia	No / Yes	
Cardiovascular	Chest pain	No / Yes	
	Shortness of breath	No / Yes	
	Heart attack	No / Yes	
	High blood pressure	No / Yes	
	Blood clots in legs or lungs	No / Yes	
	Swelling of feet or legs	No / Yes	
	Poor circulation	No / Yes	
	Irregular heartbeat	No / Yes	
Gastrointestinal (GI)	Ulcer	No / Yes	
	Gallbladder	No / Yes	
	Hepatitis / liver trouble	No / Yes	
	Bleeding with bowel movements	No / Yes	
	Hemorrhoids	No / Yes	
	Hiatal hernia / reflux	No / Yes	
Genitourinary (GU)	Loss of urine / incontinence	No / Yes	
	Frequent urination	No / Yes	
	Burning, painful urination	No / Yes	
	Blood in urine	No / Yes	
	Kidney stones / kidney disease	No / Yes	
Gynecological (GYN)	Bleeding or other problem	No / Yes	
	Breast masses	No / Yes	
Musculoskeletal	Fractures or other injuries	No / Yes	
	Back or neck pain	No / Yes	
Neurological	Seizures or other conditions	No / Yes	
	Neuropathy	No / Yes	
	Stroke	No / Yes	
	Chronic pain	No / Yes	
	Fibromyalgia	No / Yes	
Psychological	Depression or other problems	No / Yes	
Hematological	Blood disorders or cancer	No / Yes	
	Excessive bleeding after surgery/dental work	No / Yes	

Patient Signature:_____ **Date:**_____