Hendricks Regional Health

Hendricks Regional Health Medical Group
Adult Patient Registration

Please Print Clearly

Date_____

Physician _____

Patient Information

Name _____

Address _____

City _____

State _____ Zip Code_____

Home Phone_____

Cell Phone Number _____

Work Phone Number _____

Date of Birth _____ Male ☐ Female ☐

Single ☐ Married ☐ SSN_____

Name of Employer_____

Emergency Contact _____
(**NOT** living with you)

Emergency Contact phone _____

Relationship to Emergency Contact _____

Primary Insurance _____

Secondary Insurance_____

Local Pharmacy _____
(Please list name and location)

Mail-In Pharmacy _____

Email address _____

Responsible Party (person who will receive statements)

Name_____

Address _____

City _____

State _____ Zip Code _____

Spouse Information

Name_____

Cell Phone Number _____

Work Phone Number _____

Insured Information
(only provide if other than patient)

Primary Ins: Insured Name _____

Date of Birth _____ SSN _____

Relationship to Patient _____

Secondary Ins: Insured Name _____

Date of Birth _____ SSN _____

Relationship to Patient _____

Additional Information

Race _____

Ethnicity _____
(Options: Hispanic, Non-Hispanic, Refuse to report)

Language _____

Hendricks
Regional Health

Patient Name _____

Consent to Treat

I, the undersigned, as the patient or his/her authorized representative, hereby consent to treatment by the physicians and staff of the Hendricks Regional Health Medical Group. I further authorize such medical services on any subsequent visits. I have the right to revoke this consent at any time by communicating such decision in writing.

Authorization to Release Information and Pay Benefits

I hereby authorize Hendricks Regional Health physicians, agents and employees to release to my insurance carrier or third party payers a copy of my medical records in connection with Workmen's Compensation or to release my medical records to others responsible for insurance claims and investigations

I further authorize my insurance company to pay directly to Hendricks Regional Health all payments for medical services rendered.

Guarantee of Accounts

I agree that I am financially responsible for any charges not covered by my insurance. I shall also be responsible for all reasonable costs of the collection of this account, including but not limited, client collection fees, collection agency fees, late fees, rebilling charges, interest, reasonable attorney fees and court costs on any outstanding balances. I understand I may be contacted by mail, e-mail, text messaging or any phone number associated with this account by Hendricks Regional Health and/or their agents in an effort to collect payment on my accounts. This may include the use of pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Notice of Privacy Practices and Office Policies

I was offered a copy of the Hendricks Regional Health Notice of Privacy Practices and the office policy.

Medicare Signature on File (if applicable)

I request that payment of authorized Medicare benefits be made on my behalf to Hendricks Regional Health Medical Group providers for any services furnished me by the listed provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown.

_____ _____ _____

Patient or Legal Guardian Signature | Relationship to Patient | Date

_____

Witness

Hendricks
Regional Health

At Hendricks Regional Health we take the privacy of your health information seriously. We will not release a patient's health information outside of the allowed exceptions spelled out in our Notice of Privacy Practices without your verbal or written permission.

This form gives you the opportunity to tell us who we can speak to regarding your health information. You are not required to list anyone and you can change who we are permitted speak to at any time by completing a new form.

I authorize Hendricks Regional Health Medical Group physicians and/or staff to speak to the individuals listed below regarding my health and billing information. I understand that I can revoke this authorization at any time by completing a new form.

	Name	Relationship
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

_____ _____
Signature Date

_____ _____
Patient Printed Name Date of Birth

_____
Witness

Hendricks
Regional Health

Early TB Prescreen Checklist

Patient Name _____ Date of Birth _____
(Please Print)

This is a required screening checklist. Please circle yes to any of the questions that apply. Answering yes does not necessarily indicate that you have TB.

Persistent cough greater than 3 weeks	yes	no
Coughing up blood	yes	no
Frequent night sweats	yes	no
Low-grade fever (100°-101°F) greater than 3 days	yes	no
Recent unexplained weight loss with loss of appetite	yes	no
Previous Active TB disease	yes	no
Chest x-ray suggest rule out TB	yes	no

In Office Use Only:

Comments for yes responses _____

_____

_____