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

NEW PATIENT QUESTIONNAIRE

NOTE: This is a confidential record of your medical history. Information contained here will not be released without your written consent. Please give this completed form to your physician at the time of your visit.

Date:_____ Name:_____ D.O.B.: _____

Address:_____

Home Phone:_____ Work Phone:_____ Occupation is/was: _____

Reason for your visit today: _____

Have you ever had any or the following?

	YES	NO		YES	NO
High Blood Pressure (Hypertension)			Back or joint problems (arthritis)		
Heart Disease/Stroke			Depression or severe anxiety		
Diabetes			Cancer		
Stomach or colon problems			Liver problems (hepatitis/jaundice)		
Lung problems			Thyroid problems		
Visual Impairment			Hearing problems		

List other past medical problems and dates?	**List surgical procedures and year:**

Current medications (including over-the-counter)

Name of medication	Dose	per/day	Name of medication	Dose	per/day

Do you have any drug allergies? YES NO If YES, please list below:

Name of medication	Describe reaction

Pharmacy:_____ Location:_____ Phone: _____

Please list other physicians you have seen in the last 12 months and for what reason:

Physician Name	Reason:

List other members of your household:

Do you smoke? (circle one) yes no If yes, # of packs per day Date quit:

Do you use chewing tobacco or snuff? (circle one) yes no If yes, frequency Date quit:

Do you drink alcohol? (circle one) yes no If yes, drinks per day Date quit:

Do you drink caffeinated beverages? (circle one) yes no If yes, cups per day Date quit:

Have you ever had a problem with drugs? (circle one) yes no

Are you sexually active? (circle one) yes no If yes, what type of birth control do you use?

Do exercise regularly? (circle one) yes no If yes, how many times per week?

Has an immediate blood relative had any of the following?

	YES	NO	Relation		YES	NO	Relation
Cancer				Heart Disease			
Diabetes				Other:			
Hypertension				Other:			

PLEASE TURN OVER AND COMPLETE MEDICAL HISTORY

In the **PAST 12 MONTHS** have you had any of the following symptoms?					
	YES	**NO**		**YES**	**NO**
Frequent headaches			Abdominal pain		
Fainting or passing out			Frequent constipation		
Sudden loss of vision, strength or inability to speak			Frequent diarrhea		
Hearing loss or ringing in ear(s)			Rectal bleeding/black stools		
Hoarseness for more than 2-4 weeks			Blood in urine		
Nosebleeds			Urinating more than twice per night		
Coughing for more than 2-4 weeks			Pain in joints or bones		
Coughing up blood			Unusual bruising or bleeding		
Shortness of breath or wheezing			Seizures, convulsions		
Swelling of feet or ankles			Change in wart, mole or skin growth		
Chest pain, chest pressure or heaviness			Difficulty sleeping		
Irregular heartbeat or sudden fast heartbeat			Tearfulness		
Difficulty swallowing or food “sticking”			Difficulty concentrating		
Frequent heartburn or indigestion?			Weight loss more than 5-10 pounds		

Other symptoms: _____

_____

_____

Date of last rectal exam? _____

Have you ever had a blood transfusion? ☐ YES ☐ NO

Do you have a Living Will? ☐ YES ☐ NO

Immunizations:			
	Last date vaccine received		**Last date vaccine received**
Tetanus		Hepatitis	
Pneumonia		Flu	
Measles, Mumps, Rubella			

For Women Only

Date of last pap: _____ Where was this performed? _____

Date of last mammogram: _____ Where was this performed? _____

Number of pregnancies: _____ Number of deliveries _____

Date of last menstrual period: _____ Date of onset of menopause: _____

Do you do breast self-exams? ☐ YES ☐ NO

Do you have irregular menstrual bleeding? ☐ YES ☐ NO

Do you have menstrual bleeding after menopause? ☐ YES ☐ NO

Do you have breast lumps/discharge from nipple(s)? ☐ YES ☐ NO

Have you been a victim of abuse? ☐ YES ☐ NO

Do you feel safe at home? ☐ YES ☐ NO

MERCYHEALTH

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

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

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

1ROI

OFFICE USE ONLY
Acct/MRN
Initials
Pages
Date

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Complete all sections entirely. If this authorization 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 #:**

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

☐ Defiance Hospital ☐ Defiance Clinic ☐ St. Anne ☐ St. Charles ☐ St. Vincent ☐ Tiffin ☐ Willard ☐ Napoleon Clinic

☐ 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)

I authorize disclosure of the above listed information to the following individual or organization:

Name: _____

Information to be disclosed via: (Check one)

☐ Mail to Address: _____
Street City State Zip Code

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

☐ Pick up location/site: _____

☐ Purpose for disclosure: _____
(Continuation of care, Insurance, Legal, Please specify) – For Personal use if not otherwise stated

- I understand and acknowledge that the requested health information to disclose may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS related conditions, and/or alcohol/drug abuse. This authorization does not include disclosure of Psychotherapy notes (not included in the Mercy Health Legal health record – separate authorization, only provider/author of notes can disclose)
- This authorization will expire one year from the date of signature below unless otherwise specified.
- I understand and acknowledge that I have the right to cancel/revoke this authorization in writing to the Health Information Manager or other designated representative at the site the authorization was submitted to. This does not apply to information that has already been disclosed. This does not apply to Treatment, Operations or Payment disclosures to insurance companies when the law gives the right to the insurers to contest a claim under policy
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain treatment unless the sole purpose for the treatment is the disclosure of information for which this authorization is necessary. I understand that I may inspect or copy the information to be used or disclosed as provided by the federal government's rules, which are stated in the United States Code of Federal Regulations at section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I can contact the Privacy Officer for the site I have requested information from
- **If this authorization is not complete, it may be returned and may result in information not being released until properly completed**
- There may be a charge for copies of records

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

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

Witness (optional):_____