Columbus Regional Health Network

ORG# _____

MRN# _____

Patient Registration-Adult

	Patient	Parent/Responsible Party- *if different*
		Patient Relationship ☐ Child ☐ Spouse ☐ Other
Legal Last Name		
Legal First Name, Middle		
Nick Name		
SSN		
Date of Birth		
Sex	☐ Male ☐ Female	
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Widow	
Address		
Apt/Bldg/Suite #		
City, State, Zip		
Home Phone		
Work Phone		
Mobile Phone		
Email Address		
Employer Name		
Address		
City, State, Zip		

Emergency Contact	Reason for visit _____
Name	
Home Phone	
Work Phone	Who referred you? _____
Mobile Phone	Permission to leave voice mail @ primary phone number? ☐ Yes ☐ No

	Primary Insurance	Secondary Insurance
Insurance Company		
Primary Policyholder Name		
Primary Policyholder DOB		
Primary Policyholder Sex	☐ Male ☐ Female	

Primary Care Physician _____ If none, do you need help finding a Primary Care Physician? ☐ Yes ☐ No

Authorization, Assignment of Benefits, and Referral Medical Release

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to Columbus Regional Health Network for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: _____ Date: _____

Request for Treatment:

The Group maintains personnel and facilities to assist my physicians in providing my medical care, and I authorize the Group personnel to perform the care ordered by my physicians. I understand that I have the right to be informed by my physicians of the nature and purpose of any proposed procedure and any available alternative methods of treatment, together with an explanation of the risk associated with each procedure. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to recognized standards of medical practice, and I acknowledge that the Group and its personnel are responsible for providing this information.

Signed: _____ Date: _____

Today's Date _____ Chart # _____

Name: _____ MRN # _____

INDICATE WHICH APPLY TO YOU

GENERAL	Yes	No
1. Frequent infections	☐	☐
2. Weight change	☐	☐
3. Appetite/thirst change	☐	☐
4. Excessive fatigue/nervousness	☐	☐
5. Difficulty sleeping	☐	☐
6. Enlarged/tender lymph nodes or glands	☐	☐
7. Other _____		

EYES	Yes	No
1. Do you wear glasses/contacts	☐	☐
2. Vision changes	☐	☐
3. Red/itchy, watery eyes	☐	☐
4. Eye pain	☐	☐
5. Glaucoma	☐	☐
6. Dry eyes	☐	☐
7. Other _____		

EARS	Yes	No
1. Infections	☐	☐
2. Hearing loss	☐	☐
3. Earaches	☐	☐
4. Ear drainage	☐	☐
5. Buzzing/ringing	☐	☐
6. Feel "stopped up"	☐	☐
7. Other _____		

NOSE AND THROAT	Yes	No
1. Nasal stuffiness/drainage	☐	☐
2. Frequent nosebleeds	☐	☐
3. Sore throat	☐	☐
4. Mouth sores/ulcers	☐	☐
5. Hoarseness	☐	☐
6. Changes in taste	☐	☐
7. Teeth/gum problems	☐	☐
8. Snoring	☐	☐
9. Sleep apnea *(stop breathing while sleeping)*	☐	☐
10. Other _____		

PULMONARY	Yes	No
1. Shortness of breath/difficulty breathing	☐	☐
2. Cough-dry/productive	☐	☐
3. Asthma/wheezing	☐	☐
4. Night sweats	☐	☐
5. Fever/chills	☐	☐
6. Other _____	☐	☐

CARDIOVASCULAR	Yes	No
1. Heart attack/failure/angina	☐	☐
2. Chest pain/tightness	☐	☐
3. Irregular heartbeat	☐	☐
4. High blood pressure	☐	☐
5. Swelling of feet/ankles	☐	☐
6. Leg cramps with walking	☐	☐
7. Mitral Valve/Murmur	☐	☐
8. Other _____		

GASTROINTESTINAL	Yes	No
1. Heartburn /indigestion	☐	☐
2. Difficulty swallowing	☐	☐
3. Stomach pains/ulcers	☐	☐
4. Nausea/vomiting	☐	☐
5. Vomiting blood	☐	☐
6. Loose stools/diarrhea	☐	☐
7. Constipation	☐	☐
8. Hemorrhoids	☐	☐
9. Rectal bleeding	☐	☐
10. Black/bloody stools	☐	☐
11. Changes in bowel habits	☐	☐
12. Frequent laxatives	☐	☐
13. Liver problems/jaundice/ hepatitis	☐	☐
14. Gallstones	☐	☐
15. Other _____		

BREAST	Yes	No
1. Lumps	☐	☐
2. Pain	☐	☐
3. Discharge	☐	☐
4. Other _____		

MALES ONLY	Yes	No
1. Prostate problems	☐	☐
2. Sexual difficulties	☐	☐
3. Testicle pain/lumps/swelling	☐	☐
4. Impotent	☐	☐
5. Discharge	☐	☐
6. Do you do regular testicle exams	☐	☐
7. Date of last prostate exam / PSA _____		
8. Venereal disease	☐	☐
9. Genital concerns	☐	☐
10. Other _____		

FEMALES ONLY	Yes	No
1. Excessive menstrual flow	☐	☐
2. Excessive menstrual pain	☐	☐
3. Vaginal discharge/odor	☐	☐
4. Vaginal dryness	☐	☐
5. PMS symptoms	☐	☐
6. Menopause/symptoms	☐	☐
7. Trouble conceiving	☐	☐
8. Problems with pregnancies	☐	☐
9. Sexual difficulties	☐	☐
10. Venereal disease	☐	☐
11. Genital concerns	☐	☐
12. Self breast exams per year ____		
13. Do you use birth control Type _____	☐	☐
14. Date of last pap _____		
15. History of Abnormal Pap Treatment _____	☐	☐
16. Date of last mammogram _____		
17. Age at onset of periods _____		
18. Frequency of periods _____		

FEMALES ONLY *(continued)*
19. Last menstrual period _____
20. Pregnancies _____
21. Live births _____
22. Miscarriages/abortions _____
23. Other _____

MUSCULOSKELETAL	Yes	No
1. Joint pain/tenderness	☐	☐
2. Joint swelling/warmth	☐	☐
3. Joint stiffness	☐	☐
4. Joint deformity	☐	☐
5. Muscle pain	☐	☐
6. Back/neck pain	☐	☐
7. Weakness	☐	☐
8. Prone to falls	☐	☐
9. Other _____	☐	☐

SKIN	Yes	No
1. Rashes	☐	☐
2. Dry/itchy skin	☐	☐
3. Bruising	☐	☐
4. Sweats	☐	☐
5. Mole/lesion changes	☐	☐
6. Skin color changes	☐	☐
7. Skin growths	☐	☐
8. Hair/nail problems	☐	☐
9. Other _____		

NEUROLOGIC	Yes	No
1. Headaches/migraines	☐	☐
2. Dizziness/nausea	☐	☐
3. Fainting/blackouts	☐	☐
4. Numbness/tingling	☐	☐
5. Paralysis	☐	☐
6. Seizures/convulsions	☐	☐
7. Coordination problems	☐	☐
8. Memory loss	☐	☐
9. Other _____		

PSYCHIATRIC	Yes	No
1. Mental illness	☐	☐
2. Anxiety	☐	☐
3. Depression	☐	☐
4. Suicidal thoughts	☐	☐
5. Overly emotional/mood swings	☐	☐
6. Hallucinations	☐	☐
7. Phobias	☐	☐
8. Other _____		

URINARY	Yes	No
1. Pain/burning on urination	☐	☐
2. Urinary frequency	☐	☐
3. Difficulty starting urine	☐	☐
4. Incontinence *(wetting)*	☐	☐
5. Bloody urine	☐	☐
6. Other _____		

Provider Review: _____ Date: _____

Provider Review: _____ Date: _____

Provider Review: _____ Date: _____

Date _____

Adult Patient History

Chart # _____

MRN # _____

Name: _____ Age: _____ Date of Birth _____ Sex: M F

Marital Status: Single Married Widowed Divorced Occupation: _____

Spouse/Significant Other Name: _____ Education: Highest Level Completed _____

What is the reason for your visit today? _____ Who referred you? _____

Vaccines	Approximate Date	Exams	Approximate Date
Tetanus		Last Dental exam	
Flu		Last Eye exam	
Hep B		Last Chest X-ray	
Pneumovax		Last Colonoscopy/Sigmoidoscopy	
MMR		Last Mammogram	
Chicken pox		Last Pap Smear	
TB skin Test Positive Negative		Last Physical Exam	
		Last Prostate Exam/PSA	
		Other	

FAMILY HEALTH HISTORY:

Check (✔) if you or any blood relative has or has had any of the following and enter their relationship to you: *(Use the following abbreviations)* ***Y - yourself M - mother F - father B - brother S - Sister GF - grandfather GM - grandmother C - child***

Condition	Relationship	Condition	Relationship
Heart disease		Rheumatic fever	
Lung disease *(asthma, bronchitis, emphysema, TB, etc.)*		Stomach/Intestinal disorders	
Cancer *(breast, prostate, melanoma, leukemia, etc.)*		Gallbladder disorders	
Stroke		Thyroid disorders *(goiter)*	
High Blood Pressure		Gout	
Diabetes		Skin disorders	
Liver disease *(hepatitis, cirrhosis, jaundice, etc.)*		Depression or other Mental Illness	
Kidney disorders *(including kidney stones)*		Sexually transmitted disease *(HIV, Herp., PID, etc.)*	
Arthritis		Alcohol/Drug abuse	
Blood disorders *(anemia, bleeding disorders, etc.)*		Risk factors for HIV	
High Cholesterol		Migraines/Headaches	
Allergies *(food, seasonal)*		Other	

Current Medications – Prescription and Over-The-Counter Meds.
(including vitamins, herbs, aspirin, antacids, injectables, hormones)

Birth Control *(Oral, Injectable)*

Are you allergic to any medicine? ☐ **Yes** ☐ **No**
Please list all medications and reactions

Past hospitalizations/surgeries/serious injuries
(including blood transfusions)

Do You	Yes	No	Type	Amt./Day	Date Quit
Use tobacco products	☐	☐			
Consume alcohol	☐	☐			
Drink caffeine	☐	☐			
Use or used illegal drugs	☐	☐			
Exercise regularly	☐	☐			
Have diet restrictions	☐	☐			
Travel outside US	☐	☐			

See Reverse Side

Columbus Regional Health Network

ACKNOWLEDGEMENT FORM

Medical Records # _____

Patient's Name: _____ Date of Birth _____/_____/_____
Day Month Year

We are required by law to provide you with our Notice of Privacy Practices which explain how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

Signature:_____ Date: _____
(Patient or Authorized Representative)

Relationship to Patient: _____ Self _____ Spouse _____ Other _____

Reason Patient Unable/Unwilling to Sign: _____

_____

ACKNOWLEDGEMENT FORM
DOCUMENTO DE RECONOCIMIENTO DE COLUMBUS REGIONAL HEALTH NETWORK

Numero de Registro Medico _____

Nombre del Paciente _____ Fecha de Nacimiento ____/____/____
Dia Mes Ano

La ley nos requiere que nosotros le proveamos a usted con nuestro Aviso de Practicas de Privacidad las cuales explican como podemos usar y divulgar su informacion medica. La ley tambien nos requiere que obtengamos su firma, reconociendo que este aviso lo hemos hecho disponible para usted.

Firma: _____ Fecha: _____
(Paciente o Representante Autorizado)

Relacion al Paciente: _____ Mismo _____ Esposo (a) _____ Otro _____

Razon Por la Cual El Paciente No Puede/No Desea Firmar:_____

CONSENT FOR COMMUNICATION FOR INVOLVEMENT OF CARE

I, the undersigned, do hereby consent and request that Southeast Primary Care communicate with or release health information concerning me, if communication is in by best interest and is only information that is directly relevant to designed individual's involvement with my health care and treatment decisions.

Patient's Name_____ DOB_____

1. NAME AND ADDRESS OF PERSON WHO I WANT TO HAVE HEALTH INFORMATION AS OUTLINED ABOVE.

   NAME_____ RELATIONSHIP TO PATIENT _____

   ADDRESS_____

   _____

   PHONE: _____

2. NAME AND ADDRESS OF PERSON WHO I WANT TO HAVE HEALTH INFORMATION AS OUTLINED ABOVE.

   NAME_____ RELATIONSHIP TO PATIENT _____

   ADDRESS_____

   _____

   PHONE: _____

3. NAME AND ADDRESS OF PERSON WHO I WANT TO HAVE HEALTH INFORMATION AS OUTLINED ABOVE.

   NAME_____ RELATIONSHIP TO PATIENT _____

   ADDRESS_____

   _____

   PHONE: _____

_____PRINTED NAME _____

SIGNATURE OF PATIENT OR AUTHORIZED PARTY/DATE _____

I DO NOT GRANT CONSENT FOR ANYONE TO BE GIVEN INFORMATION REGARDING MY HEALTH CARE OR TREATMENT EXCEPT REQUIRED BY LAW.

_____ PRINTED NAME_____

SIGNATURE OF PATIENT OR AURTHORIZED PARTY/DATE

Columbus Regional Health Network

REQUEST FOR RELEASE OF MEDICAL RECORDS

Regarding Patient: **Medical Record Number:** _____

Last Name First Name MI

Street Address

City State Zip Code

Date of Birth Social Security Number

Information Released From:

Name *(Health Care Provider)*

Street Address

City State Zip

Phone Fax

Information Released To:

Name *(Hospital, MD, Agency, Etc.)*

Street Address

City State Zip

Phone Fax

Purpose for Release of Records:

- ☐ Continuing Treatment
- ☐ Legal Investigation
- ☐ Worker's Compensation
- ☐ Personal
- ☐ Change in Insurance
- ☐ Moving
- ☐ Staff/Physician Issues
- ☐ Disability Determination
- ☐ Other: _____

I hereby release you from all legal responsibility or liability that may arise from this authorization.

Witness Signed *(Full Name)*

Date

NOTICE: This authorization is for **FULL DISCLOSURE OF ALL RECORDS,** including clinical findings, diagnosis, treatment, assessment, recommendations for further care, names of health care personnel, dates of hospitalizations and ambulatory visits, charges, and any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease, including HIV/AIDS information. Such records will be disclosed unless specified information to exclude is listed below.

Exclusions: _____

Health Information Released By:

Name Title Date

White - Send with Records *Canary - Chart Copy*

Columbus Regional Health Network

PAYMENT POLICY & PATIENT STATEMENT OF RESPONSIBILITY

TO OUR VALUED PATIENTS:

THANK YOU for choosing Columbus Regional Health Network for your healthcare services. We strive to provide the highest quality of care yet keep your healthcare costs as low as possible. These policies reflect our efforts to reduce healthcare costs. We appreciate your full cooperation.

FOR YOUR CONVENIENCE we accept any debit or credit card with the MasterCard, Visa, Discover, or American Express logo, as well as your personal check or cash.

PAYMENT (such as co-pays, deductibles & co-insurance) is required at the time of service. We request that you do not ask to be billed. Patients repeatedly asking for exceptions will be directed to a supervisor or practice manager.

INSURANCE CARDS must be presented at each visit. You may feel this is unnecessary, but insurance plans are becoming more complicated, and cards, policy numbers, and renewal dates are constantly changing. In order for us to file your claims with the appropriate plan, we must have the most recent card presented. **If you arrive without your card**, you will be responsible for all charges until the billing office has received complete, current, and accurate insurance information. Most plans require we file your claim within 90 days from the date of service. If we have not received your information within that time, you will remain responsible for all charges incurred up to the date you provide us with your insurance information and we receive payment from the insurance plan. Any balance you owe should be paid within thirty days.

MEDICARE PLANS are more numerous and complicated. Columbus Regional Health Network participate with **Traditional Medicare (Part A & Part B)** and a limited number of Private Fee-for-Service (PFFS) Medicare Advantage Plans. We do not accept any Non Private Fee-for-Service Plans except for emergency situations. Please notify the front office immediately if you have recently changed Medicare plans. Medicare deductibles and co-insurance are expected at the time of service. As a participating provider with Medicare and a limited number of PFFS, we will file your claim to Medicare and if applicable, to your secondary insurance carrier.

MANAGED CARE PLANS have a network of participating providers. We participate with most major plans, but please contact your plan or check their website or call our office for confirmation before your visit. Applicable co-pays, co-insurance and deductibles are expected at time of service. You will also be billed for any non-covered services for which you are liable after your insurance pays their share. If you have a managed care plan that we do not participate with, you will be expected to pay the bill in full at the time of service.

OTHER INSURANCES are those plans we do not participate in. You may be responsible for payment in full at the time of service. As a courtesy, we will file your claim.

WORKER'S COMPENSATION may or may not be accepted by your provider. Please check with your provider before making an appointment. If your provider accepts Worker's Compensation, you will be seen upon approval and authorization by your employer with the proper documentation.

MEDICAID may not be accepted by your provider. Please check with your provider's office before making an appointment. If your provider does accept Medicaid, **you will need to bring your current Medicaid Identification Card to each visit.** Failure to bring the current card may result in your appointment being rescheduled. If there is a co-pay with your plan, you will be expected to pay it at the time of service.

HEALTH SAVINGS ACCOUNTS/HEALTH REIMBURSEMENT ACCOUNTS are being promoted so that patients can have more control over managing their health care spending. These accounts will be patient specific so it is important you are aware of all benefits, deductibles, and co-payments. The deductible and co-payment will be expected at the time of service.

SELF PAY PATIENTS are those patients who **do not have insurance coverage.** Self pay patients will be given a 25% discount off the charges for services provided and are expected to pay a minimum of $50.00 at the time of service. This discount also does not apply to those patients who may have insurance, but we do not participate with their plan.

MEDICAL FORMS/MEDICAL LEAVE/DISABILITY FORMS will be completed within 7 to 10 business days upon receiving the form in the office. Please make sure you allow plenty of time for completion of these forms. Emergencies will be handled on a case by case basis. There may also be a fee for completion of these forms.

We thank you for taking time to read and understand our policies. Please let us know if you have any questions. Again, our office should be notified immediately of any changes in insurance coverage or primary care assignment.

I understand my responsibilities as outlined above and will abide by them.

Patient/Guardian Name _____

Patient/Guardian
Signature _____ Date _____