FAC

CoxHealth

Patient Sticker

Regional Services

PATIENT REGISTRATION FORM

Patient's **Legal** Name:______________________ SSN#: ______________ Date: __________

Address: ______________________________ City/State/Zip: ______________________

Birth Date : ____/____/______ **Sex:** ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino **Language:** ☐ English ☐ Spanish ☐ Other: __________

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander

Home Phone:______________ Mobile Phone: ____________ **Email:** ______________________

Name of **Patient's** Employer: __________________________________ Work Phone: __________

Patient's Employer Address: ______________________ City/State/Zip: ______________________

Spouse Name: ______________________ DOB: ________ **Spouse** Work/Mobile Phone: __________

Emergency Contact and Relationship: ____________________ DOB: ________ Phone: __________

What is your preferred method of contact for reminders to schedule preventative or follow-up visits?
☐ Email ☐ Home Phone ☐ Letter ☐ Mobile Phone ☐ Work Phone

INSURANCE INFORMATION

Is this visit related to an accident? ☐ Yes ☐ No **If yes**, please specify if AUTO or Other: ______________

Is this visit related to a work related accident? ☐ Yes ☐ No If yes, please provide Workman's Comp Ins.

♦ PRIMARY INS:____________________ **POLICY HOLDER NAME:** ______________________

Policy Holder's Employer: ______________ Policy Holder SSN#: ______________________

Group #: ______________ Policy/ID #: ____________________ Policy Holder DOB: __________

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other (explain) ______________

♦ SECONDARY INS:____________________ **POLICY HOLDER NAME:** ______________________

Policy Holder's Employer: ______________ Policy Holder SSN#: ______________________

Group #: ______________ Policy/ID #: ____________________ Policy Holder DOB: __________

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other (explain) ______________

PARENT OR GUARDIAN INFORMATION

Complete for Patients who are Minors or Patients with Guardians ONLY

♦ RELATIONSHIP: ☐ **Father** ☐ **Mother** ☐ **Guardian**

Name: (First, MI, Last) ____________________ SSN#: ____________ Date of Birth: __________

Address: ______________________ City/State/Zip: ____________ Home Phone: __________

Employer: ______________________ Work Phone: ____________ Mobile Phone: __________

♦ RELATIONSHIP: ☐ **Father** ☐ **Mother** ☐ **Guardian**

Name: (First, MI, Last) ____________________ SSN#: ____________ Date of Birth: __________

Address: ______________________ City/State/Zip: ____________ Home Phone: __________

Employer: ______________________ Work Phone: ____________ Mobile Phone: __________

NEW PATIENTS ONLY - How did you hear about us?

☐ Physician (Recommendation/Referral) (AP)
☐ Emergency Room/Urgent Care (UC)
☐ Health Plan Directory/Insurance Company (HP)
☐ Friend/Relative/Neighbor (FR)
☐ Website - CoxHealth (WS)
☐ Heathsense Magazine (HM)
☐ Billboard/Sign (BS)
☐ Cox INFO Line (IL)
☐ Wal-mart Clinic (WC)
☐ Mailer/Postcard (MP)
☐ Online Search (OS)
☐ Phone Book (PB)
☐ Social Media (SM)
☐ Newspaper (PA)
☐ Radio (RT)
☐ TV (TV)
☐ Email (EM)
☐ Other (OT)

OVER – Please Read and Sign

"A copy of this authorization shall be as effective and valid as the original."

AUTHOR

CoxHealth
Health Information Management
AUTHORIZATION, FINANCIAL OBLIGATION and CONSENT

Name: ______________________
Age: _____ DOB: ___/___/______
SSN or ID: ______________________
(or Patient Sticker Here)

I UNDERSTAND I MAY RECEIVE SEPARATE BILLS FROM COXHEALTH, ITS AFFILIATED ENTITIES, AND CONTRACTED PHYSICIAN GROUPS.

Authorization to Release Information. I acknowledge I have received a copy of the Notice of Privacy Practices. I understand it sets forth my rights regarding my medical information and how it may be used or disclosed. I authorize the review, copying, and release of any information in my medical or billing record(s), including information regarding the diagnosis or treatment of HIV, AIDS, mental illness or substance abuse, to any person, corporation or agency responsible for determining the necessity, appropriateness, payment, continuity of care, or other matters related to the treatment or services rendered to me by CoxHealth. This includes the sharing and/or receiving of prescription information with a prescription database used for electronically prescribing medications, including prescriptions prescribed to me outside of the CoxHealth system.

Assignment of Insurance Benefits. I assign to CoxHealth the benefits otherwise payable to me for any hospitalization, outpatient services, and clinical treatment from my insurance carrier(s), managed care plan, health maintenance organization, self-insured health plan, and Medicaid or Medicare and intermediaries and carriers. I also understand I am financially responsible if my assigned insurance benefits do not cover all of the charges.

Medicare Assignment. I request payment of authorized benefits be made on my behalf to CoxHealth, and I authorize the Social Security Administration to release information regarding my eligibility for coverage under Medicare Part A and Part B, including but not limited to the effective date of such coverage, to CoxHealth. I authorize CoxHealth to obtain information from the Social Security Administration or other government agency regarding my entitlement to benefits and my health insurance claim numbers.

Financial Obligation. I understand I am financially responsible for payment of all amounts due regardless of whether I have insurance coverage or whether other parties may also be responsible for paying for my care, with the exception of certain worker's compensation claims. I understand CoxHealth will submit claims for coverage to my disclosed insurance carriers and CoxHealth is authorized to complete any forms needed to obtain payment from said payers. I acknowledge any credit balance may be applied to any open account of which I am the patient and/or responsible party. For any past due accounts, I agree to pay interest at the legal statutory rate if the amount for which I am responsible is not paid within thirty (30) days of the date of billing. I understand any unpaid balance may be the subject of legal proceedings against me, my spouse, or another responsible party, even if no request for payment or any other attempt to collect has been made. As part of the unpaid balance collection process and to contact me about my care, I authorize CoxHealth and any of its agents to contact me at any telephone number or address, including email address, I have provided to CoxHealth using any manner, including the use of an auto-dialing device or pre-recorded messages. I understand the cost of collections on past due accounts, including reasonable attorney's fees and court costs, will be included as part of my financial obligation and I hereby agree to pay such costs. This agreement shall be governed by Missouri law, with venue in Greene County, Missouri. I also understand, pursuant to the Missouri hospital lien statutes, that if my injuries were caused by the negligence or wrongful act of someone else, CoxHealth may have a lien on the proceeds of any claims or rights of action I may have against the individuals or entities which caused my injuries, and CoxHealth may have the right to enforce its lien for payment of services rendered rather than seek payment from any third-party payer.

Consent for Treatment. I agree, request, and authorize CoxHealth to provide health care services to me and further consent to any examinations, tests (including tests for drugs and/or alcohol), or procedures that may be advisable or necessary for routine diagnostic purposes, or to diagnose or treat my medical condition. I realize that among those who attend to patients at CoxHealth facilities are medical, nursing, and other healthcare personnel in training who may be present and participating in my care as part of their education. I also understand that CoxHealth utilizes the services of non-physician practitioners, that I may be evaluated and treated by one of these non-physician practitioners and that I have the right to see that practitioner's collaborating physician. I authorize the taking of photographs, videos, or other images of parts of my body for use in my medical evaluation, for education, and for security purposes. I am aware the practice of medicine is not an exact science and I understand no promise, guarantee, or warranty has been made regarding the results of the examination or treatment I receive. I agree to have my blood tested for hepatitis or HIV infection if my physician determines it is necessary or if an employee, provider, volunteer, contractor, treating physician, emergency worker, or law enforcement personnel is exposed to my blood or bodily fluids. If my blood indicates infection, my physician will be notified as well as any other individual, entity or agency required by law.

Release of Responsibility for Valuables. I understand CoxHealth strongly recommends all personal belongings and valuables not be kept in its facilities. I understand CoxHealth will not be liable for loss or damage to any personal property remaining in my possession and will not replace any personal items if they are lost or stolen.

Acknowledgments and Certifications. I acknowledge a copy of the Patient Bill of Rights and Responsibilities has been made available to me. I certify I have read and understand all parts of this form; accept all its terms and conditions; all representations made by me are true; and agree a copy of this form is effective and valid as the original. This form expires (unless expressly revoked at an earlier date) one (1) year after the date indicated below.

_______________________________ Date & Time
Patient, parent if minor child, or guardian
(If Patient unable to sign, Representative name and Relationship)

_______________________________ Date & Time
__ Primary insured if different from patient
__ Secondary insured if different from patient
__ Guarantor if different from patient

_______________________________ Date & Time
Witness

_______________________________ _______________________________ Date & Time
Interpreter Name (if used) Language & Organization

CPS-3028 (Orig.11-97 Rev.06-19 Ref:L4863)

SHARE

CoxHealth
All Entities and Locations
www.coxhealth.com

For Office Use Only
Name: ______________________
Age: ______ DOB: ___/___/______
Encounter ID: ________________
(or Patient Sticker Here)

PERMISSION TO SHARE

Permission to Verbally Share Information with Those Involved in Your Care

(Signed original will be scanned into Cerner and a copy will be provided to the patient.)

Many patients want their healthcare provider to verbally share medical and/or billing information with specific family members, friends, or others participating in their care. The purpose of this annual authorization is to communicate with your healthcare provider regarding who may have access to this information.

Patient Identification:

Legal Name: ____ Date of Birth:____/____/______

Full Address: ____

I authorize the release of financial and protected health information (PHI) from the following:

__ The entire CoxHealth system and its Affiliated Covered Entities.

- In the case of an emergency situation CoxHealth may determine that a limited disclosure may be in my best interests and I realize CoxHealth may share limited PHI or other information with those who may be involved in my care.
- I realize this form does NOT authorize the person(s) below to make healthcare decisions for me or to view or receive copies of my medical records.

			Type of Information			
Name:	Phone Number:	Relationship to Patient:	All	Scheduling / Appointment	Medical	Insurance / Billing

This covers the following time frames. If NOT marked, all past, present and future encounters are the default.

__ All past, present, and future encounters/visits -OR- Other: ______________________________

By signing this authorization form, I understand that:

- PHI may include records relating to psychiatric or psychological care; communicable diseases; HIV/AIDS diagnosis or treatment; alcohol or drug abuse treatment; sexually transmitted diseases; and other sensitive information.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Time Limit and Right to Revoke:
Except to the extent that action has already been taken in reliance on this authorization, I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to my physician's clinic if I am a clinic patient or registration/nursing staff if I am a hospital patient. Unless otherwise revoked, this authorization will expire one (1) year from the date signed.

Signature of Patient / Legal Representative:

____ Date: __________ Time: __________

Relationship to Patient: ____

Patient Name: ________________________________ **Date of Birth** ____________

Date Completed:________________

Preferred Language

__English
__Chinese
__Korean
__Romanian
__Spanish
__Vietnamese
__Other:

Communication Challenges

__None
__Aphasia
__Blind
__Deaf
__English is second language
__Non English speaking
__Other:

Teaching Method Preferred

__Demonstration
__Explanation
__Printed Material
__Video or educational TV
__Hands on
__Other:

Individuals to be Included in Teaching

__Patient
__Spouse/Significant other
__Daughter __Son
__Family member
__Parent
__Sibling

Activities needing assistance beyond developmentally appropriate care

__None of the following apply
__Bathing
__Climbing stairs
__Cooking
__Dressing
__Eating
__Grocery Shopping
__Grooming
__House keeping
__Managing finances
__Taking medicines
__Using the telephone
__Other:

Barriers of Learning:

__Cognitive deficits
__Cultural barrier
__Desire/Motivation
__Difficulty Concentrating
__Emotional state
__Financial concerns
__Hearing deficit
__Language barrier
__Literacy
__Memory Problems
__Vision impairment
__Other:

Lives With

__Alone
__Child
__Family Member
__Friend
__Parent
__Spouse/Significant other
__Other:

Factors contributing to limiting your independence

__Amputation
__Arm/Hand tremors
__Cognitive deficit
__Communication barrier
__Difficulty swallowing
__Extremity weakness
__Paralysis
__Unstable gait/balance
__Other:

Are there any spiritual beliefs, rituals, or customs you wish for us to know? __Yes __No

Caregiver to Another __Yes __No

Would you like information on Advance Directives/Power of Attorney? __Yes __No

Information given by: ________________________________

Preferred Communication Method: __Printed Letter __Phone Call __Portal

AUTHORIZATION TO OBTAIN MEDICATION INFORMATION

Name of Patient:____
(first, middle, and last name)

Date of birth of patient: ____/___/_____

TO: MY HEALTHCARE PROVIDERS, PHARMACIES and INSURANCE PROVIDERS

I hereby authorize *(give my permission for)* any of my CoxHealth providers to access information concerning my past, present, and future prescriptions. The information on my prescriptions will come from my pharmacies, my insurance providers, and an electronic health information exchange program, such as SureScripts.

Information may include:

- Eligibility, benefits and formulary information. This helps the provider to select medications that are covered by my insurance company/drug benefit plan. It also informs the provider of lower cost alternatives such as generic drugs.
- Current and past prescriptions, including those prescribed by other providers. This decreases the risk of medication issues such as harmful drug-to-drug interactions or an allergic reaction to a drug.

I further understand:

- I do not have to sign this authorization.
- My refusal to sign will not affect my ability to obtain treatment or my insurance eligibility.
- I can revoke this authorization at any time by submitting a written notice to my healthcare provider(s).
- This authorization will remain in force and effect for one (1) year from the date of my signature or until revoked by me in writing, **whichever occurs first**.
- A photocopy of this authorization will be as valid as an original.

________________________________ ________________________
[Signature of patient or legal guardian] Date

HIECON

Name: ______________________

Age: ________ DOB: ______________

Encounter ID: ______________
(or Patient Sticker Here)

CoxHealth

AUTHORIZATION AND CONSENT FOR PARTICIPATION IN HEALTH INFORMATION EXCHANGES

CoxHealth understands that patients may receive medical care from our healthcare professionals, healthcare professionals outside of our network, and healthcare professionals outside of our geographic area. Your treating providers need to have a complete and up-to-date picture of your health to provide quality medical care, particularly during emergencies. Additionally, providing current and accurate information to your providers is essential for quality improvement and care coordination. By signing this form, you give permission to allow your health care providers to share and access your health records electronically, through various computer networks, in order to better care for you.

PLEASE READ THE STATEMENTS BELOW

By signing this form, I understand CoxHealth participates in Health Information Exchanges and I agree any participant of a Health Information Exchange in which CoxHealth participates, including any substance use provider, may make my health information available to CoxHealth through the relevant Health Information Exchange. I further understand CoxHealth will make my health information available through Health Information Exchanges to other participants. I understand CoxHealth and other Health Information Exchange participants:

- Will share and access my health information for treatment, payment, and health care operations purposes, and may request, view, print and store my health information by secure means;
- Will share and access all my health records from both before and after the date this form is signed;
- May use or share my health information, but only as allowed by federal and state laws;
- May access and share ALL my health records with providers treating me, including but not limited to: illnesses or injuries, such as diabetes or broken bones; test results such as X-rays and blood tests; medications and prescriptions I am taking or have taken; and other types of general information, such as employment information, living and housing situations, and my social history. Further, this information may include sensitive information such as alcohol or substance abuse problems; genetic (inherited) diseases or test results; HIV/AIDS status; mental or behavioral health and developmental disabilities; family planning information (including abortions); sexually transmitted diseases; and head and spinal cord injuries;
- May copy or include my health information in their own medical records when caring for me. Even if I later cancel my consent, providers I have visited who have copied my records are not required to remove them;
- Have policies and penalties in place for anyone that shares or accesses my data inappropriately, and will ensure the individual Health Information Exchanges will keep track of who views my health information to make sure it is an appropriate access done in a secure manner. I can ask CoxHealth and the individual Health Information Exchanges for a list of who has looked at my records.

I also understand and agree that:

- Using my health information for marketing/advertising purposes or to determine insurance or employment eligibility is strictly prohibited;
- My consent will remain in effect until I revoke my consent in writing to the CoxHealth HIPAA Privacy Officer; however, I understand such revocation will not apply to any access to, or sharing of, my health information that occurred prior to the date the written revocation was received;
- My consent to share my information is voluntary and my decision not to share my information will not affect my ability to receive care from CoxHealth;
- This form shall apply to all current Health Information Exchanges that CoxHealth participates in as well as all future exchanges it may choose to join;
- I may ask for a copy of this form after I sign it and this form replaces any previous Health Information Exchange consent and opt-out forms I have completed at CoxHealth prior to today.

By signing this form, I give CoxHealth and all Health Information Exchange participating providers the right to share and access all my health records, including sensitive data, through the various Health Information Exchange's networks for purposes of providing care to me.

Printed Name (include maiden name)	Date of Birth	Today's Date
My Address (City, State, and Zip Code)	My E-mail Address	
My or My Legal Representative's Signature*	Printed Name of Legal Representative	
Relationship of Legal Representative		

** If I am the parent or guardian of a minor child, I can consent on behalf of the child only until he or she turns 18 years old. At that time, the child will be opted out of most Health Information Exchanges and he or she will have to choose to re-join.*