Horizon Healthcare
An Affiliate of
Fairfield Memorial Hospital

PATIENT REGISTRATION FORM

213 NW 10th Street, Suite A
Fairfield, IL 62837
Ph 618-8424617
Fax 618-842-4743

Please present Driver's License & Insurance Cards for Copy

PATIENT INFORMATION:

Legal Name ______________________________ Maiden Name ________________
FIRST MIDDLE LAST

Social Security Number ________________ Date of Birth ________ Age: ____ ◯ Male ◯ Female

Address ______________________ City ______________ St ____ Zip ________

◯ Home Phone ____________ ◯ Cell Phone ____________ ◯ Work Phone ____________

(Please check your preferred phone)

Email Address: ______________________________ (***we will not share this with other entities***)

Preferred Language:
__ English __Spanish __French __Chinese __Other

Ethnicity:
__Hispanic or Latino __Non-Hispanic or Latino

Religious Preference ____________ (if none, please write N/A) **Race:** ______________

Marital Status
__Single __Married __Domestic Partner __Life Partner __Divorced __Separated __Widow __Minor

Do you have any Advanced Directives: __Yes __No **If 'Yes', please provide us with a copy of Advanced Directives.**

Do you have any hearing or vision impairment: __No __Yes, hearing __Yes, vision Explain: ____________

EMPLOYER: ______________________________

GUARANTOR INFORMATION: (*Complete this section if patient is a minor, or if someone other than patient is responsible for charges not paid by insurance*)

◯ **Same as patient**

Guarantor's name ____________________ Relationship to Patient ____________

Guarantor's Phone #: ____________ Guarantor's Date of Birth: ________ SS #: ____________

Address: ______________________ City ______________ St ____ Zip ________

◯ ***Check here if address is same as patient***

EMERGENCY CONTACT FOR PATIENT:

Name: ________________ Relationship: ____________ Phone: ____________

Secondary Contact/Support Role: Name ____________ Relationship ____________ Phone ____________

IF PATIENT IS A MINOR, HAVE YOU COMPLETED A "WHEN YOU'RE NOT THERE" FORM? ***__YES*** ***__ NO***

If NO, please ask your customer service representative for a form.

Primary Insurance	**Secondary Insurance**
Insurance Company Name: ____________	Insurance Company Name: ____________
Policyholder's Name: ____________	Policyholder's Name: ____________
Policyholder's Date of Birth: ______ SS#: ______	Policyholder's Date of Birth: ______ SS#: ______
Address: ____________	Address: ____________
City: ________ State: ____ Zip: ______	City: ________ State: ____ Zip: ______
Employer: ____________	Employer: ____________
Relationship to Patient: ____________	Relationship to Patient: ____________
Effective Date of Coverage: ____________	Effective Date of Coverage: ____________
◯ ***SAME AS PATIENT***	◯ ***SAME AS PATIENT***
◯ ***SAME AS GUARANTOR***	◯ ***SAME AS GUARANTOR***

If any of the information above changes, please notify us in a timely manner. *If patient is unable to sign and you are Healthcare Power of Attorney or Legal Guardian, you must provide us with legal documentation for our records*. If applicable, please provide us with a copy of Advanced Directives as well.

SIGNATURE: ______________________________ **DATE:** ____________

RELATIONSHIP TO PATIENT: ______________________

REV 10/2018

AUTHORIZATION TO VERBALLY RELEASE MEDICAL INFORMATION

If we needed to call you about health information or schedule changes, please specify whether or not we may leave a message on the following phones:

	Leave Message?		
Cell Phone:	__Yes	__No	Phone Number: ____________________
Home Phone:	__Yes	__No	Phone Number: ____________________
Alternate Phone:	__Yes	__No	Phone Number: ____________________

May we text you regarding appointment schedule changes if we cannot reach you by phone? __Yes __No

****

There may be times when friends or family members, ***including spouses***, may inquire about your healthcare, such as appointment times, prescription refills, test results, or general medical health information. This is ***protected information***, and we cannot share that with anyone unless you have listed their name on this form. Please read carefully and choose ***only 1*** of the 3 options below.

1. ___ I DO NOT WANT ANY OF MY INFORMATION RELEASED TO ANYONE, INCLUDING MY SPOUSE.

2. ___ I would like to name the following family member(s) or friend(s) as someone with whom Horizon Healthcare can share any of my information with, including psychiatric health, drug and alcohol treatment, and communicable diseases:

Name ______________________________ Relationship ______________________________

Name ______________________________ Relationship ______________________________

Name ______________________________ Relationship ______________________________

Name ______________________________ Relationship ______________________________

3. ___ I would like to name the following family member(s) or friend(s) as someone with whom Horizon Healthcare can share information regarding ***only the following medical information/conditions***:

____

____

Name ______________________________ Relationship ______________________________

Name ______________________________ Relationship ______________________________

I understand and acknowledge by signing below that it is my responsibility to notify Horizon Healthcare when any information changes, including but not limited to phone number, ability to leave a message, and those that may verbally have my information released to them.

Signature: ______________________________ Date: ____________________

PATIENT, PARENT, OR LEGAL RESPONSIBLE PARTY IF DOCUMENTATION ON FILE

Relationship to patient: ______________________________ Patient's Date of Birth: __________

(PARENT, POA, LEGAL GUARDIAN, ETC)

Witness: ______________________________

REVISED DECEMBER 2018

Patient Name: ________________ Today's Date: ________________

Patient Medical History

PLEASE PRESENT THIS COMPLETED FORM TO THE WINDOW IN SUITE A SO THAT IT CAN BE ROUTED TO YOUR NURSE PRIOR TO YOUR APPOINTMENT.

Patient Name: ______________________________________ Date of Birth: __________ Age: _____
Last First M.I.

Person completing form if patient is a minor: ________________________ Relationship: ______________

Primary Pharmacy: ____________________________ City of Pharm: ________________________

Secondary Pharmacy: __________________________ City of Pharm: ________________________

ALLERGIES: ____

Medical Diagnosis – Circle all that apply- Please include year of diagnosis, past and present:

Y / N Allergies ______________
Y / N Anemia ______________
Y / N Angina ______________
Y / N Anxiety ______________
Y / N Arthritis ______________
Y / N Asthma ______________
Y / N Atrial Fibrillation _______
Y / N Benign Prostate Hyperplasia _____
Y / N Blood clots ___________
Y / N Cancer – Year Diagnosed______
Type: ____________________
Y / N Cardiac Arrhythmia _________
Y / N COPD ________
Y / N Coronary Artery Disease_____
Y / N Depression _______
Y / N Diabetes – Year Diagnosed _____
Type: ____________________

Y / N Elevated Lipids ____________
Y / N Gallbladder Disease ________
Y / N GERD _______
Y / N Headache/migraines ________
Y / N Heart Disease ____________
Y / N Heart Valve Disease ________
Y / N Hepatitis/Liver Disease ______
Y / N Hypertension ____________
Y / N Irritable Bowel Syndrome ____
Y / N Myocardial Infarction ______
Y / N Osteoporosis ____________
Y / N Renal Disease ___________
Y / N Seizure Disorder __________
Y / N Stroke ________________
Y / N Thyroid Disease __________

Other / Explain: ____

Surgical History

Type of Surgery	Date of Surgery	Surgeon (if known)

If you have had more than five major surgeries, please attach list to this sheet. Thank you.

Last Mammogram: ___/___/___ Tdap Vaccine: ___/___/___
Last Pap Smear: ___/___/___ Influenza Vaccine ___/___/___
Last Colonoscopy: ___/___/___ Pneumococcal Vaccine: ___/___/___

Patient Name: ________________ Today's Date: ________________

Patient Medical History

Family History – (Disease process that could affect you, the patient)

Father - ________________________________
Mother - ________________________________
Sibling(s) - Brother: ________________ Sister: ________________
Child(ren) - Son: ________________ Daughter ________________
Maternal Grandmother - ________________________________
Maternal Grandfather - ________________________________
Paternal Grandmother - ________________________________
Paternal Grandfather - ________________________________

Social History

Do you use tobacco? Y N What type: ________________
How much do you chew/smoke per day? ________________
Are you a former Smoker? Y N Year you Quit: ________________
How many years have/did you smoke/use tobacco? ________________
Are you currently using any recreational drugs? Y N Name of Drug/s: ________________
Are you a former drug-user? Y N Year you Quit: ________________
How many years have/did you use drugs? ________________
Do you drink alcohol? Y N How often/amount? ________________
Type of alcohol (circle all that apply): Beer Wine Liquor
Do you consume caffeine on a daily basis? Y N Cups per day: ________________
Marital Status: Single Married Divorced Separated Widowed
Occupation: ________________

Advanced Directives

Living Will	Y	N
Do Not Resuscitate (DNR)	Y	N
Healthcare Proxy	Y	N

Power of Attorney (POA) Y N
Name of POA: ________________
Phone Number of POA: ________________
Relationship of POA: ________________

PLEASE BRING A COPY OF YOUR ADVANCED DIRECTIVES/POA FORM TO YOUR APPOINTMENT.

Consulting Physicians

Please list any other providers you are currently seeing:

Name of Physician	Specialty	Phone Number
________________	________________	( ) _____-_______
________________	________________	( ) _____-_______
________________	________________	( ) _____-_______
________________	________________	( ) _____-_______
________________	________________	( ) _____-_______

Patient Name: ________________ Today's Date: ________________

Patient Medical History

PEDIATRIC QUESTIONNAIRE

Who does patient live with? (Mother, Father, Stepparents, Grandparents, etc.)

____

Names of all in household where patient lives	Relationship to Patient	Phone Number
______________________	______________	( ) _____-______
______________________	______________	( ) _____-______
______________________	______________	( ) _____-______
______________________	______________	( ) _____-______
______________________	______________	( ) _____-______

Please list any child care the patient may have (nanny, sitter, day care, mother, father, etc): ____________

____

Are there Smokers at home? Y N Indoor or Outdoor Both

Grade in school ______________ School Attending ______________________________

PLEASE BRING A COPY OF YOUR CHILD'S IMMUNIZATION RECORDS TO YOUR APPOINTMENT.

FAIRFIELD MEMORIAL HOSPITAL ASSOCIATION

ASSIGNMENT OF INSURANCE BENEFITS

I represent that I presently maintain medical insurance coverage which will reimburse the charges for the hospital and medical care being provided. If my medical insurance coverage is not sufficient to satisfy the hospital charges in full, I acknowledge that the resulting balance is not covered by this Assignment and I will be fully responsible for payment of this balance due upon receipt of patient bill as consideration for hospital and medical services rendered, and I agree to pay the established rates of Fairfield Memorial Hospital (FMH) and its physicians or independent contractors for all services, facilities, and supplies rendered.

In consideration of those hospital and medical services rendered by FMH, I hereby assign, transfer, and set over to FMH all of my rights, title, and interest to medical reimbursement, and all other rights and privileges including, but not limited to, the right to designate a beneficiary, add dependent eligibility, and to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscriptions certificate, or other health benefit indemnification agreement otherwise payable to me for those services rendered by FMH.

FINANCIAL AGREEMENT

I, the undersigned, agree, whether signing as an agent or as the patient, that in consideration of the services to be rendered to the patient, to pay the account of the patient in accordance with the regular rates and terms of the hospital within 30 days upon receipt of the patient bill. Should the account be referred to an attorney and/or collection agency for collection, the undersigned shall pay all court costs, collection agency fees, attorney fees, and all other expenses incurred with collection. I agree that I may be contacted by telephone at any telephone number associated with my account, including wireless (cellular) telephone numbers, which could result in additional charges to my telephone bill. Provider reserves the right to decilne further services to the patient without notice; to accept periodic installment payments without waiving its rights to demand payment in full; and the right to assign monies due. This Assignment shall be binding upon all heirs, personal representatives, and successors. I further authorize FMH to apply any overpayment on any accounts to any other unpaid accounts that Ior my guarantor have.

PRE-CERTIFICATION REQUIREMENTS

If my insurance company or third party payor requires pre-certification, I understand that it is my responsibility to contact them to obtain authorization for services.

I have had the opportunity to discuss this form and understand the contents.
A copy of this signature is as valid as the original. Authorization is valid from this date forward unless revoked.
Authorization shall also apply for any physician services for whom FMH is authorized to bill.

_____ Patient Signature — I, the undersigned, am the patient, and hereby consent to and accept the terms above.

_____ Other Signature — I, the undersigned, hereby certify, that the patient is unable to grant consent or is a minor and I, the undersigned, hereby consent to and accept the terms of the above as agent, guardian, parent, committee, or attorney in fact.

_____ Implied Consent _____ Verbal Consent

____

Signature of Patient or Legal Representative Date

____

Relationship to Patient

____

Signature of Witness Date

FAIRFIELD MEMORIAL HOSPITAL ASSOCIATION

ACKNOWLEDGEMENT OF LEGAL RELATIONSHIP

I understand that Fairfield Memorial Hospital Association (FMH) employs the following practitioners:

Christopher Ballard, MD
Wesley Thompson, MD
Marla Lafikes, MD
Nicole Fyie, MD
Kayla Bell, PA-C
Sherry Funkhouser, PA-C
Kristen Harris, PA-C
James Hopper, PA-C
John Snowden, PA-C

Heather Curtis APN FNP
Catherine Durbin, APN FNP
Ross Herdes, APN, FNP
Renee Kohlman, APN, FNP
John Larrison, APN FNP
Sherry Mewes, APN FNP
Carrie Nussmeyer, APN, FNP
Dylan Wayne Stennett, APN FNP
Alexis King, CRNA

Paige Williams, CRNA
Kimberly King, CRNA
John Wall, CRNA
John Allen, CRNA
Gabriel Gigliotti, CRNA
Benjamin Curtis, CRNA
Thomas Falcone, CRNA
Jill Barnfield, LCSW
Nicole Uhlmann, LCSW

I acknowledge and understand that most physicians, consultants, surgeons, hospital-based physicians such as pathologists, radiologists, emergency physicians, anesthesiologists, and non-physician providers such as surgical vendor representatives, who provide services at FMH are not employees or agents of FMH, but instead are independent medical practitioners or contractors. I understand that each of these providers exercises his or her own, independent medical judgment and is solely responsible for the care, treatment, and services that he or she orders, requests, directs, or provides. I ACKNOWLEDGE THAT THE EMPLOYMENT OR AGENCY STATUS OF PHYSICIANS AND OTHER PROVIDERS WHO TREAT ME IS NOT RELEVANT TO MY SELECTION OF FMH FOR MY CARE. I also understand that I will receive, am solely responsible for payment of, a separate bill from each of these independent practitioners, or groups of practitioners, for care, treatment, or services provided. These independent contractor physicians and groups include, but are not limited to:

Rodney Beeler, MD
Douglas Frankel, MD
James Gruber, MD
Jasiri Kennedy, MD
Michelle O'Neill, MD
Scott Roustio, MD
Antonio Rodriguez, MD

Steven Mitchell, MD
Justin Miller, MD
Clinical Radiologists
Deaconess Heart Group
Cancer Care Specialists of Southern Illinois
Southern Illinois Surgical Care Associates
Premier Pathology Group, LLC

Gary Reagan, MD
Dwight Silvera, MD
Sajjan Nemani, MD

Mark Murfin, MD
Jennifer MIller, DPM
Sridhar Bhaskara, MD

I certify:

1. That I have read or have had this consent read to me;
2. That I was given an opportunity to ask questions; and
3. That all questions were answered to my satisfaction

Signature of Patient or Legal Representative Date

Relationship to Patient

Signature of Witness Date

FAIRFIELD MEMORIAL HOSPITAL ASSOCIATION

CONSENT FOR MEDICAL TREATMENT

I request and authorize my physician and any other physicians consulted upon my behalf and Fairfield Memorial Hospital (FMH) and its employees and agents who attend me, to provide and perform such medical care, tests, examinations, treatment, anesthesia, procedures, administer drugs, and provide other services and supplies as are considered advisable for my health and well-being. I acknowledge that the practice of medicine is not an exact science and that no guarantee has been given to me by anyone as to the results of treatments or medical care performed in the hospital. I acknowledge and understand that physicians,consultants, surgeons, hospital-based physicians such as pathologists, radiologists, emergency physicians, and non-physician providers, who provide services at Fairfield Memorial Hospital are not employees or agents of Fairfield Memorial Hospital, but instead are independent medical practitioners or contractors. I acknowledge that the employment or agency status of physicians and other providers who treat me is not relevant to my selection of Fairfield Memorial Hospital for my care. This consent includes testing for blood-borne infectious disease(s), including but not limited to Hepatitis and Acquired Immune Deficiency Syndrome (AIDS), and Human Immunodeficiency Virus (HIV) if a physician orders tests for diagnostic purposes.

PERSONAL PROPERTY (Money and Valuables)

The undersigned certifies that the patient is advised to send all monies and valuables home and if that is not possible, to deposit monies and valuables with the hospital for safe keeping. The patient is further advised that the hospital cannot accept any liability for such monies and other valuables of whatever nature that the patient might take, or have, on the patient floor.

RELEASE OF INFORMATION

I authorize FMH to notify my referring physician, if any, of my addmission to the hospital and to release any information about me as requested by my referring physician. I authorize the hospital to release medical information, financial information, and hospital medical records to the following persons or goups: (a) any third party payor which is or may be liable to the hospital or my physician for all or part of their charges, including but not limited to insurance companies, worker's compensation carriers, the Social Security Administration or its intermediaries, or my employer; (b) any person or entity for peer review, quality management, or utilization review; (c) any person or entity for scientific, educational, research or statistical purposes, including but not limited to the Cancer Registry; (d) any physician or medical provider who providers care or services to me. This includes information relative to substance abuse (including but not limited to alcohol or drugs), psychological or psychiatric conditions and Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency virus (HIV).

MEDICARE INPATIENTS ONLY

I certify that the information given by my in applying for payment under Title XVIII of the Social Security Act is correct. I acknowledge that I have received a copy of "An Important Message from Medicare." My signature only acknowledges my receipt of this message and does not waive any of my rights to request a review or make me liable for any payment.

A copy of this signature is as valid as the original.

_____ Patient Signature — I, the undersigned, am the patient, and hereby consent to and accept the terms of the above.

_____ Other Signature — I, the undersigned, hereby certify, that the patient is uable to grant consent or is a minor and I, the undersigned, hereby consent to and accept the terms of the above as agent, guardian, parent, committee, or attorney in fact.

____
Signature of Patient or Legal Representative

____
Relationship to Patient

______________________________ ______________
Signature of Witness Date

FAIRFIELD MEMORIAL HOSPITAL ASSOCIATION

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Fairfield Memorial Hospital reserves the right to modify the privacy practices outlined in the notice. By signing below, I acknowledge that I have received a copy of the Privacy Notice for Fairfield Memorial Hospital.

(Name of Patient)

Signature of Patient or Patient Representative ________ Date ________

Relationship to Patient ________

_____Unable to obtain signature due at the time of registration due to emergency treatment. Privacy notice was still given to the patient/patient representative and an attempt will be made after the situation is resolved to obtain a signature.

Please describe emergency situation____

____

Signature of Staff ________ Date ________

Follow-up to obtain signatures after the emergency situation has been resolved:

Signature of Patient or Patient Representative ________ Date ________

Signature of Staff ________ Date ________