Century Regional Health Care

Patient Information Record

Thank you for choosing our office! In order to serve you properly, we require the following information. **Please print.** All information will be kept confidential.

Patient Information

Date: _____ Patient Name: _____ Patient #: _____
Address: _____ SS#: (For Reporting Labs & Imaging) _____
City: _____ State: _____ Zip: _____ Date of Birth: _____
Home Phone: _____ Work Phone: _____
Marital Status: S / M / W / D / SEP Driver's License#: _____
Male / Female (circle one) How were you referred? : _____
Employer: _____ Occupation: _____
Responsible Party's name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
EMAIL Address:

Primary Insurance

Primary Insurance Company: _____ Insured Employer: _____
Subscriber ID#: _____ Group #: _____
Insured Name: _____ Date of Birth: _____
Insured Address: _____ Patient Relationship to insured: _____

Secondary Insurance

Secondary Insurance Company: _____ Insured Employer: _____
Subscriber ID#: _____ Group #: _____
Insured Name: _____ Date of Birth: _____
Insured Address: _____ Patient Relationship to insured: _____

Emergency Contact Person

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

If you would like any information concerning Advanced Directives ask your provider!

Date: _____ Name: _____ Patient #: _____

Release of Information

I hereby authorize Century Regional Health Care to release information to my insurer(s), their agent(s), (including employer, if work related injury) about my injury or disability, medical condition, evaluation, treatment, or any and all medical information as may be necessary for payment of my hospital, medical, or nursing home claims, except as otherwise provided by applicable State or Federal laws. This release also allows information to be released for utilization review and financial audits, or for the purpose of evaluation, treatment, and/or rehabilitation. This may include all reports and others contained in the medical record pertaining to the medical condition or injury for which I have sought treatment. This also allows Century Regional Health Care to send records to referred physician for the purpose of continued care. This will include all documentation in the chart. Also, any medical information returned from the referral physician used for case management purposes can be released to the above entities. I understand that this authorization can be revoked by me at any time and that is valid for the entire time I remain a patient of Century Regional Health Care. Century Regional Health Care and its personnel are hereby released from all legal responsibility for such release of information as described above. A photocopy of this document shall be considered to be as valid as the original.

Benefit Assignment

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to Century Regional Health Care. A photocopy of this assignment is to be considered to as valid as the original.

Consent for Medical Treatment

I, the undersigned, as the patient (or the patient's duly authorized representative) do hereby voluntarily consent to and authorize medical care encompassing all diagnostic and therapeutic treatments and transfers to the other facilities considered necessary or advisable in the judgment of the attending physician, his/her assistants or designee. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations performed in this facility. I authorize Century Regional Health Care to dispose of any specimens or tissues removed from my body at their convenience. This form has been fully explained to me and I certify by my signature that I understand and accept its contents, except as noted.

Financial Responsibility Statement

It is our practice to bill your insurance carrier as a courtesy to you, even though you may be responsible for the entire bill at the time of your visit. If your insurance carrier doesn't remit payment within 60 days, the applicable balance will then be due in full from you. Unless your insurance company has a contract with us to pay based on a specific negotiated fee schedule, you may be held responsible for any difference between the insurance payment and the total charges.

We also require that arrangements for payments of your estimated share be made today. If any payment is subsequently made by your insurance carrier in excess of the balance of your account, we will promptly refund the credit. If any payment is made directly to us for your services billed by us, you recognized an obligation to promptly remit same to us.

If you are a worker's compensation patient, you will only be held responsible for your charges in the event your claims are not approved by either your employer or insurance company.

You understand and agree that if you fail to make any of the payments for which you are responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Century Regional Health Care, you will be responsible for all costs of collecting monies owed including court costs, collection agency fees and attorney fees. You also understand that you are responsible for advising us of any changes in your address or phone number. If any correspondence is returned, you understand that the account will be considered in default and will be turned over for collection immediately.

The above information has been read or has been read to you and your signature below signifies that you understand your responsibilities for the payment of your account.

_____	_____
Patient or Responsible Party	Date
_____	_____
Company Representative	Date

HEALTH HISTORY

Please print all information. All questions must be answered on **front and back**.

Name: _____ Date: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Social Security#: _____ Occupation: _____

IMMUNIZATIONS

Check any immunization(s) that you have had and the date

- ☐ Rubella _____
- ☐ Measles _____
- ☐ Tetanus _____
- ☐ Pneumovax _____
- ☐ Hepatitis B _____
- ☐ Influenza _____

Last TB skin test _____

☐ Negative ☐ Positive

HEALTH MAINTENANCE

Date of last:

- ☐ DEXA _____
- ☐ EKG _____
- ☐ Colonoscopy _____
- ☐ PSA _____
- ☐ Cholesterol _____
- ☐ Physical _____
- ☐ Chest X-Ray _____
- ☐ Stool occult Blood test _____

MEDICATIONS

List all drugs or medications you use regularly (include birth control pills and non prescription items—laxatives, pain pills, cold tablets, etc.)

_____ _____

_____ _____

_____ _____

_____ _____

When was your last immunization? (Tetanus-lock jaw, diphtheria,etc.) _____

PAST MEDICAL HISTORY

	YES	NO	Other
Allergies	_____	_____	_____
Diabetes	_____	_____	_____
Elevated Cholesterol	_____	_____	_____
Cancer	_____	_____	_____
Stroke	_____	_____	_____
High Blood Pressure	_____	_____	_____
Infection History	_____	_____	Specify: _____
Accidents	_____	_____	Specify: _____

Do you have any allergic reaction to any food or medications? _____ YES _____ NO

If yes, LIST: _____

PAST SURGICAL HISTORY

List hospitalizations/surgeries and dates:

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY

Do you smoke cigarettes? _____YES _____ NO How many each day? _____

How much alcohol do you drink each day? _____

Do you use any narcotics or other addictive drugs? _____

Lifestyle (married, divorced, widowed) / Recent changes in lifestyle? _____

Do you wear your seatbelt? ☐ Never ☐ Sometimes ☐ Always

Do you exercise? ☐ Never ☐ Sometimes ☐ Always

WOMEN'S HEALTH

Date of last menstrual period (first day): _____

Date of last pap smear: _____

Number of pregnancies: _____ Number of live births: _____

Date of last mammogram: _____

FAMILY HISTORY

Has any member of your family had any of the following conditions?

	YES	NO	RELATIONSHIP	ALIVE
Diabetes	_____	_____	_____	_____
Cancer (specify type)	_____	_____	_____	_____
Heart Problems	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Stroke	_____	_____	_____	_____
Other	_____		_____	
	_____		_____	
	_____		_____	

Have you ever had a TB (tuberculosis) skin test? _____ YES _____ NO

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

CENTURY REGIONAL HEALTH CLINIC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Overview

The law requires us to keep your protected health information ("PHI") private in accordance with this Notice of Privacy Practices ("Notice"), as long as this Notice remains in effect. We are also required to provide you with a paper copy of this Notice, which contains our privacy practices, our legal duties, and your rights concerning your PHI. From time to time, we may revise our privacy practices and the terms of our Notice at any time, as permitted or required by applicable law. Such revisions to our privacy practices and our Notice may be retroactive. Our Notice will be updated and made available to our patients prior to any significant revisions of our privacy practices and policies.

Organizations Covered by this Notice [Optional Language for Organized Health Care Arrangements]

This Notice contains the privacy practices for [types of organizations] listed below, with the [types of facilities] sites they maintain for delivery of healthcare products and services. Each of these organizations participates in an organized health care arrangement and may use and disclose your PHI among themselves as they shall deem appropriate for your treatment, payment or health care operations.

Our Privacy Practices

Use and Disclosure We may use or disclose your PHI for treatment, payment, or health care operations. For your convenience, we have provided the following examples of such potential uses or disclosures:

Treatment. Your PHI may be used by or disclosed to any physicians or other health care providers involved with the medical services provided to you.

Payment. Your PHI may be used or disclosed in order to collect payment for the medical services provided to you.

Health Care Operations. Your PHI may be used or disclosed as part of our internal healthcare operations. Such health care operations may include, among other things, quality of care audits of our staff and affiliates, conducting training programs, accreditations, certification, licensing, or credentialing activities.

Authorizations. We will not use or disclose your medical information for any reason except those described in this Notice, unless you provide us with a written authorization to do so. We may request such an authorization to use or disclose your PHI for any purpose, but you are not required to give us such authorization as a condition of your treatment. Any written authorization from you may be revoked by you, in writing at any time, but such revocation will not affect any prior authorized uses or disclosures.

Patient Access. We will provide you with access to your PHI , as described below in the Individual Rights section of this Notice. With your permission, or in some emergencies, we may disclose your PHI to your family members, friends, or other people to aid in your treatment or the collection of payment. A disclosure of your PHI may also be made if we determine it is necessary or in your best interests for such purposes as allowing a person acting on your behalf to receive filled prescriptions, medical supplies, X-rays, etc.

Facility Directories. [Optional Language for Inpatient Facilities] Our facility directory may list the following information about you: (1) your name, (2) your location in our facility, (3) your general condition without reference to specific medical information, *e.g.,* stable, serious, fair, etc., and (4) your religious affiliation, if any. Our facility directory information may be disclosed to clergymen and, except for religious affiliation, to other people. You may restrict or prohibit the release of the above information.

Locating Responsible Parties. Your PHI may be disclosed in order to locate, identify or notify a family member, your personal representative, or other person responsible for your care. If we determine in our reasonable professional judgment that you are capable of doing so, you will be given the opportunity to consent to or to prohibit or restrict the extent or recipients of such disclosure. If we determine that you are unable to provide such consent, we will limit the PHI disclosed to the minimum necessary.

Continuing Care. Based upon your PHI, we may provide you with appointment reminders or information concerning health issues, benefits and services, or treatment alternatives that we believe may be of interest to you.

CENTURY REGIONAL HEALTH CARE

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative (Agent) of the Patient acknowledges that he or she personally received a copy of the CENTURY REGIONAL HEALTH CARE's Notice of privacy Policies on the date indicated below.

Signature: _____ Date: _____

Patient: _____

I give permission for the following persons to have access to my medical records/results:

_____

_____

_____

_____

Signature: _____ Date: _____

Patient: _____

Information about Agent (attach appropriate documentation):

_____

_____

_____

Financial Policy

Thank you for choosing Century Regional Health Care as your health care provider. Our personnel will be happy to discuss our fees and this policy with you at any time. Please read and sign this financial policy prior to seeing the provider. Payment for services is due at the time services are rendered. For any portion of your balance that is not covered by insurance, or for our private pay patients, we accept cash, check, VISA and MasterCard.

1.) Your insurance policy is a contract between YOU, YOUR employer and the insurance company. We are NOT a party to that contract. Our relationship is with YOU. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges secondary insurance and the "usual and customary charges".
We are, however, contracted with most managed care plans. Please present your insurance card at the front desk so that we can file a claim on your behalf. We will follow their guidelines for submission of claims, co-pay amounts, and reimbursements. Any contracted provider discounts will be deducted from your balance.
2.) All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies and some employers decide what is a covered benefit and what is not. Please check your insurance plan document for any questions. Fees for these services along with unmet deductibles and co-payments are due at the time of treatment.
3.) Co-payments not paid at the time of service are subject to a $10 processing fee.
4.) If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. If your insurance company does not pay within 60 days, you will be responsible for payment.
5.) Returned checks and balances older than 90 days may be subject to collection agency placement and collection fees.
6.) Please note that all cancellations must be made at least 24 hours in advance which allows us to care for other patients in need of our services. If you fail to cancel your appointment, you will be assessed a service fee which is not a covered benefit under your insurance.
7.) Occasionally a refund is due to you. We will issue a refund check after we have received payment from your insurance company. This check will be processed on the 15th and 30th of each month for balances above $10.00. All others will remain a credit on your account.
8.) We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to our Patient Billing Department so that we can assist you in the management of your account.

Again, thank you for choosing Century Regional Health Care. We truly appreciate the opportunity to serve you!

_____ _____

Patient's Signature Today's Date

Notice of Office Policy

Dear Patients:

Weekly our office has 30 missed appointments.

That means:

- Weekly 30 times our staff spent time on the phone to make the appointment.
- Weekly 30 times our staff called to remind of coming appointment.
- Weekly 30 times our staff called the insurance company to verify coverage.
- Weekly 30 times our staff pulled the chart.
- Weekly 30 times our staff reviewed the chart.
- Weekly 30 times our computer memory was used to list a missed appointment.
- Weekly 30 times our staff had to file the chart away.
- Weekly 30 people had to wait that much longer for their appointment.

Therefore:

All missed appointments and cancellations with less than 24 hours notice will be charged $50.00. You need to pay the $50.00 before a new appointment can be made.
INSURANCE DOES NOT PAY FOR THIS.

Medical forms brought in at time of appointment will be filled out within 10 business days. Return to work/school forms and prescriptions will be filled out within 48 hours of the day you called.

_____	_____	_____
Patient name	Patient Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date