REGIONAL PHYSICIAN SPECIALISTS

IN CASE OF EMERGENCY, WHO SHOULD BE CONTACTED?

PLEASE PRINT CLEARLY

REFERRING PHYSICIAN:			
PATIENT NAME:		Date of Birth:	Age:
Address:		Social Security #:	
City:		Home Phone:	
State:	Zip:	Marital Status: __S __M __D__W	Sex: __M __F
EMPLOYER:		Work Phone:	
Address:		Occupation/Position:	
City:		State:	Zip:
DO YOU HAVE MEDICARE? YES or **NO**		**DO YOU HAVE MEDICAID? YES** or **NO**	
DO YOU HAVE MEDICAL INSURANCE? YES or **NO**		**NAME OF INSURANCE:**	
PERSON RESPONSIBLE FOR BILL (if other than patient or insurance is in spouse's name)			
Name:		Relationship to Patient:	
Address:		Social Security #:	
City:		State:	Zip:
Home Phone:		Date of Birth:	
Employer:		Work Phone:	
IS THIS A WORK COMP CLAIM?	**If so, who is your employer?**		Phone:
IN CASE OF EMERGENCY, WHO SHOULD BE CONTACTED?			
Relationship to Patient:		Phone:	
WHAT PHARMACY DO YOU USE?		Phone:	

AGREEMENT: By signing this document I warrant the foregoing information to be true. I agree to pay all bills upon receipt or expressly agreed. I authorize the release of all medical information necessary to process any insurance claims filed on my behalf and request payment of Medicare or other insurance benefits whether to myself, _____. I hereby authorize Regional Physician Specialists to investigate any date obtained from me pertaining to my financial responsibility.

Signature:	Date:

REGIONAL PHYSICIAN SPECIALISTS

GENERAL CONSENT TO TREAT AND ACKNOWLEDGEMENT OF BENEFITS RELEASE

Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provide by Regional Physician Specialists and its associated physicians, clinicians, and other personnel. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

Assignment of Insurance Benefits

I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and Regional Physician Specialists. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand that Regional Physician Specialists can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection or collected, I/we shall pay all collections fees and cost, including reasonable attorney's fees. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

Signature of Patient/(Guardian or Legally Authorized Representative)	Date
Signature of Witness	Date

REGIONAL PHYSICIAN SPECIALISTS

THANK YOU FOR VISITING US HERE AT REGIONAL PHYSICIAN SPECIALISTS TODAY.

YOUR OPINION COUNTS!

Help us improve the care we deliver by completing an email survey about your visit.
It will only be used to help us improve our quality of care

Our survey partner, Press Ganey, will hold your information in strict confidence.

They will not:

- Sell your information to a third party.
- Use your email for promotional marketing.

They will keep your information confidential, and in compliance with HIPAA patient privacy regulations.

Physician Seeing Today:
Patient Name:
Date of Birth (mm/dd/yy):
Email Address:
Check here if you do not have email: ☐

From everyone here at Regional Physician Specialists, thank you for trusting us with your care.

REGIONAL PHYSICIAN SPECIALISTS

Financial Policy

Thank you for choosing **Regional Physician Specialists** as your health care provider. It is our goal to meet patient needs and address patient concerns effectively.

An area of primary concern for all patients are the financial policies of the practice, especially those pertaining to insurance billing and patient payment requirements. In an effort to keep patients informed about such policies, we ask that all patients read and sign a copy of our Financial Policy prior to receiving treatment.

As in all aspects of healthcare today, the greater role the patient assumes in the healthcare process the higher the degree of satisfaction achieved. For that reason, we expect our patients to take an active role in their healthcare management, including the area of finances.

- PAYMENT POLICY AGREEMENTS are presented for completion and signature upon each visit, prior to treatment.
- PAYMENT is expected at the time services are rendered. This includes all deductibles, co-insurance, and co-payments. Patients who have an insurance carrier with who the practice has a valid contract will be responsible for all fees as outlined in the patients' contract agreement.
- DEPOSITS are collected for all procedures over $250.00. The deposit is to be paid prior to actual date of the procedure.
- INSURANCE will be filed as a courtesy to our patients.
- RETURNED CHECKS will result in a $25.00 service charge. The check amount plus the service charge is to be paid within 10 day of notification. Failure to pay in full will result in collection through the magistrate court.
- STATEMENTS & BILLINGCORRESPONDENCE are sent to update the patient as to the status of the account and whether your insurance company has fulfilled their obligations to you, the policy owner, to pay claims in a timely manner.
- DELINQUENT ACCOUNTS are placed for collections 90 days from the date the service was rendered. Patients having financial difficulties are encouraged to discuss them frankly with our financial counselor before the account becomes delinquent.
- MOTOR VEHICLE ACCIDENT CLAIMS will require that a lien is signed at the time of service. Insurance will be filed with verification only.
- WORKER'S COMPENSATION CLAIMS are filed only if verification can be completed. The patient is responsible for providing all necessary information.

I have read the Financial Policy of Regional Physician Specialists. I understand and agree to adhere to the policies as outlined.

Signature of Responsible Party	Date
Signature of Witness	Date

Regional Physician Specialists

PRIVACY NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document (a) an individual's acknowledgement of receipt of our Privacy Practices Notice or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

Patient Name: _____

Medical Record Number: _____ Social Security Number: _____

Date of Admission: _____ Notice Version (Date): _____

Acknowledgement of receipt of Privacy Practices Notice

I, _____, acknowledge that I have received a Privacy Practices Notice from:

Further, by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment and health care operations as discussed in the Notice of Privacy Practices.

Patient Signature: _____ Date: _____

☐ Notice has previously been distributed by another location in our OHCA (except for physicians):

List location that distributed the Joint Notice: _____

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

IF NOT SIGNED: (Good faith effort to obtain acknowledgement of receipt)

Describe your good faith effort to obtain the individual's signature on this form:

_____

_____

_____

Describe the reason why the individual would not sign this form: _____

_____

_____

SIGNATURE: (Hospital Representative)

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

Include this acknowledgement form in the individual's records.

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Date:_____

Name:_____ DOB:_____

Chief Complaint: (explain your symptoms/problems)

_____

_____

_____

Accident/Injury: Yes No Date of Injury:_____ Work Related? Yes No Filing Work Comp?_____

Past Medical History: (circle all that apply)

Addiction -Alcohol/Drugs	Fractures	Seizure Disorders
Allergies/Asthma	Gout	Stroke
Alzheimer's	Heart Problems	Thyroid Problems
Angina/Chest Pain	Hepatitis	Ulcers
Arthritis/Osteoarthritis	HIV/AIDS	Any Other not listed:_____
Blood Clots/Phlebitis	Hyperlipidemia	Surgeries: _____
Blood Pressure	Kidney Problems	_____
Cancer	Liver Disease	_____
Circulation Problems	Lung Disease	_____
Depression	Osteoporosis	Anesthesia History: Any problems in the past? Yes No
Diabetes	Prostate	If yes, explain: _____

Medication Allergies:_____

Current Medications: (list all you are taking including all over the counter such as vitamins or supplements):

_____

_____

_____

Have you ever taken: Steroids (Prednisone, Medrol, other) Yes or No/Blood Thinners (Coumadin, Plavis, other) Yes or No

Chemotherapy (Cancer Medicine) Yes or No If yes to any above, list which drug and when you took it:_____

_____

Social History: (circle all that apply)

Marital Status: Married, Single, Divorced, Widowed

Highest Level of Education:_____

Alcohol: Yes No How Much/often?_____ Tobacco Use: Yes No Quit Date: _____

Dominant Hand: Left Right

Family History (circle all that apply):

Arthritis Asthma Blood Disorders Diabetes Gout Heart Disease

Hypertension Osteoarthritis Osteoporosis Seizures Strokes

Tuberculosis Other: _____

REGIONAL PHYSICIAN SPECIALISTS

REVIEW OF SYSTEMS

Date:_____

Name:_____ DOB:_____

Please circle all CURRENT ISSUES that apply:

General:

Recent Weight Changes: Yes No How Much?_____ + / –

Good Appetite: Yes No Fevers/Chills/Sweat: Yes No

Skin:

Lesions: Yes No Itching: Yes No Rashes: Yes No

Other:_____

Head:

Vision Hearing Sinuses Headaches/Dizziness Dental Issues

Respiratory:

Asthma/Wheezing Shortness of Breath Cough Blood in Sputum

Cardiac:

Chest Pain Angina Edema/Swelling Heart Irregularities

Gastrointestinal:

Abdominal Pain Blood in Stool Constipation Ulcers Diarrhea Diverticulitis

Genitourinary:

Urinary Problems Incontinence Burning Kidney Stones Catheter

Musculoskeletal:

Joint Pain Neck Pain Swelling of Joints Sprains Back Pain

Morning Stiffness Fever in Joints Muscle Weakness

Neuro/Psychiatric:

Seizures Speech/Swallowing Problems Depression Memory Problems

Numbness in Arms/Legs Sleep Disorders Change in Sensation

Hematologic/Lymphatic:

Enlarged Lymph Nodes Anemia Bleeding Tendency Blood Thinners

Allergic/Immunologic:

HIV/AIDS Hepatitis A B C Psoriasis Hives Dermatitis Eczema

Other:_____

_____

Regional Physician Specialists
AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Fax Number: _____

☐ **Access Request to Copy/Inspect**

I authorize the use/disclosure of health information about me as described below:

1. The following organization is authorized to make the disclosure:

_____
Name of Facility

_____
Address

2. The type of information to be used or disclosed is as follows (please include dates of service)

Date(s) of Service: _____

☐ Complete Medical Record

☐ Abstract of Medical Record (H&P, Discharge Summary, Consultation Reports, Operative & Procedure Reports, EKGs, Laboratory, X-ray and imaging reports)

☐ History & Physical (H&P)
☐ Discharge Summary
☐ Operative Report
☐ Consultation Reports
☐ X-ray and imaging reports
☐ Progress Notes
☐ Laboratory Test Results
☐ Immunization Record

☐ Other- list specific Items: _____

Behavioral Health Reports:

☐ Social History
☐ Client Data Form
☐ Referral/Treatment Form
☐ Admission Evaluation
☐ Notification of Admission
☐ Treatment Plan
☐ Academic History
☐ Aftercare Instructions
☐ Psychological Evaluation

☐ Other – list specific items: _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol abuse.

This information is being provided to you from records whose confidentiality may be protected by State and/or Federal law.

4. I understand that your facility may receive compensation for medical record copying in accordance with State law.

5. This information may be disclosed to and used by the following individual/organization:

Name: _____

Address: _____

For the purpose of:

☐ Further Medical Care
☐ Inspection/Copying of my records
☐ Personal
☐ Other (please specify):_____
☐ Insurance Eligibility/Benefits
☐ Legal Investigation or Action
☐ Changing Physicians

6. I understand I have the right to inspect and obtain a copy of my protected health information in the designated record sets you or your business associates maintain. I understand however I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use of or for any civil, criminal or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988, (42 U.S.C. section 263 (a), and certain other records.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization as described in #6 above.

8. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under the terms of this authorization.

9. I understand that I may revoke this authorization in writing at any time. To understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. **This authorization expires within 90 days, unless otherwise specified.**

_____ _____
Signature of Patient Date

(If signed by someone other than the patient, indicate relationship and authority to do so.)

_____
Name of Patient (Please Print)

Patient is:
☐ Minor ☐ Incompetent
☐ Disabled ☐ Deceased

Legal Authority:
☐ Custodial Parent
☐ Executor of Estate of Deceased
☐ Authorized Legal Personal Representative
☐ Legal Guardian
☐ Power of Attorney for Health Care

_____ _____
Signature of Witness Date