SEYMOUR HOSPITAL RURAL HEALTH CLINIC
PATIENT REGISTRATION

PATIENT'S LAST NAME: ____________________ **FIRST NAME:** ________________ **MIDDLE NAME:** ____________________

PATIENT'S SOCIAL SECURITY NUMBER: ______-_____-_________ **AGE:** __________ **GENDER:** MALE / FEMALE

DATE OF BIRTH: MONTH __________ DAY _____ YEAR ______ **Pharmacy** ______________________________________

MAILING ADDRESS: __________________________ **CITY/STATE/ZIP** __________________________ **COUNTY** ___________

HOME PHONE: ( ) ___________ **CELL PHONE** ( ) ______________ **EMAIL:** _____________ ____________________

MAIDEN NAME: ______________________ **PREVIOUS/PRIOR NAME:** __________________ **NICKNAME:** _________________

RACE: ________________ **ETHNICITY (Circle one):** Hispanic or Latino Not Hispanic or Latino Declined to specify

MARITAL STATUS (Circle): SINGLE SEPARATED MARRIED WIDOWED DIVORCED

PRIMARY LANGUAGE SPOKEN AT HOME: ___________________

TOBACCO HISTORY:

Smokeless Tobacco : (Circle Any that apply)

Does not use moist Powdered tobacco Never used moist powdered tobacco Ex-User of moist powdered tobacco.

Never chewed tobacco Snuff user User of moist powdered tobacco Chews tobacco Tobacco consumption unknown

Smoker (Circle ANY that apply)

Current every day smoker Current some day smoker Former smoker Never smoked Smoker/current status unknown

Heavy tobacco smoker Light tobacco smoker Unknown if ever smoked

Smoker Start Date: _____________________ Smoker End Date: ______________________

GUARANTOR (PERSON RESPONSIBLE FOR ACCOUNT): ____

GUARANTOR'S SOCIAL SECURITY NUMBER: _____/___/______ DOB: _____/___/________

GUARANTOR MAILING ADDRESS: ____ PHONE NUMBER: ________________

MOTHER'S NAME: ____

FATHER'S NAME: ____

IN CASE OF EMERGENCY

NAME OF RELATIVE OR FRIEND NOT LIVING WITH YOU _____________________________ RELATIONSHIP ________________

HOME PHONE: ________________________ WORK CELL PHONE ____________________

EMPLOYER INFORMATION:

NAME OF EMPLOYER: _________________________________ ADDRESS: ____

WORK PHONE: ________________________________ OCCUPATION: ____

INSURANCE INFORMATION: (NEED COPY OF INSURANCE CARD)

PRIMARY INSURANCE: MEDICARE / MEDICARE MANAGED CARE / MEDICAID / MEDICAID MANAGED CARE / BCBS / OTHER

INSURED/SUBSCRIBER: ____________________ DOB: __________ RELATIONSHIP TO PATIENT: __________

PHONE: __________ ADDRESS: ____________________

City/State/Zip Code ____________________ INSURED'S SS#: __________

EMPLOYER OF INSURED/SUBSCRIBER: ____________________

EMPLOYER'S ADDRESS: ____________________

CONTRACT/MEMBER ID #: __________ GROUP NAME: __________

GROUP #: __________

INSURANCE EFFECTIVE DATE: __________ PATIENT'S RELATIONSHIP TO INSURED: SELF/SPOUSE/CHILD/OTHER

SECONDARY INSURANCE:

INSURED/SUBSCRIBER: ____________________ DOB: __________ RELATIONSHIP TO PATIENT: __________

PHONE: __________ ADDRESS: ____________________

City/State/Zip Code ____________________ INSURED'S SS#: __________

POLICY # __________

CONSENT FOR TREATMENT: I, the undersigned, as the patient (or on behalf of the patient) do herby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advised in the judgment of the provider on duty. I understand that no guarantee or assurance has been made as to the results which may be obtained.

ASSIGNMENT OF BENEFITS: I, the undersigned, herby authorize that any benefits or fees payable to me by any insurance company be paid directly to Seymour Hospital Rural Health Clinic and/or any ancillary providers. I understand that that this order does not relieve me of my obligation to pay the account. I understand that I am responsible for health insurance deductibles, copays and coinsurance.

FINANCIAL AGREEMENT: I hereby guarantee payment for services rendered at the Seymour Hospital Rural Health Clinic. I understand that it is the Clinic's policy to collect for charges at the time they are performed and that the Clinic accepts no liability or responsibility in settling disputed claims with insurance companies, employers or legal cases. I understand that the Clinic holds the patient or responsible party, as stated below liable for payment of all charges and does not accept an insurance company as guarantor of my account. I understand that I will be held responsible for any court costs, legal fees or agency fees which may be incurred in the collection of the account.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Seymour Hospital Rural Health Clinic. I understand that I am financially responsible for any balance. I also authorize Seymour Hospital Rural Health Clinic or my insurance company to release any information required to process my claim.

CONSENT FOR RX HISTORY: I the undersigned, agree to allow the clinic to retrieve my RX History in order to ensure that they have accurate medication records.

TELEPHONE CONSUMER PROTECTION ACT: You agree, in order for us to service your account or to collect monies you may owe, SHRHC, and/or agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text message or emails, using email address you provide to use. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing services as applicable. I/We have read this disclosure and agree that SHRHC, its employee and/or agents may contact me/us as described above

Patient/Guardian Signature____________________ Date Signed: __________

SEYMOUR HOSPITAL RURAL HEALTHCLINIC

AUTHORIZATIONS, CONSENTS AND AGREEMENTS

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RELEASE OF MEDICAL INFORMATION: To assure continuity of care between settings, organizations and providers, I hereby consent and authorize the Seymour Hospital Rural Health Clinic to release any necessary mediacal information in my record whenever I am referred for consultation or treatment. This includes sharing of the entire record as needed between Seymour Rural Health Clinic and Seymour Hospital and any other entities associated with the above. I understand and give consent for the release of my medical records from this clinic to any of the above-named facilities or associated entities. I understand that medical information may include sensitive information, i.e. drug and alcohol information, if any. I further consent and authorize the Seymour Hospital Rural Health Clinic to Release or review my medical record as necessary for determination or collections of insurance benefits and/or in the performance of quality review, maintaining measures of confidentiality and security.

MEDICARE & MEDICAID BENEFICIARIES ONLY: I certify that the information given in applying for payment under title XVII of the Social Security Act and/or Title XIX is correct. I authorize the release of all records required to act on this request so that payment of authorized benefits be made to Seymour Hospital Rural Health Clinic.

I HAVE READ THE AUTHORIZATIONS, CONSENTS AND AGREEMENTS, AND I ACCEPT THE TERMS AS DESCRIBED ABOVE. THIS AUTHORIZATION SHALL BE VALID UNTIL REVOKED IN WRITING BY THE PATIENT.

______________________ SIGNATURE OF PATIENT OR LEGALLY RESPOSIBLE PARTY (PLEASE STATE RELATIONSHIP TO PATIENT)

______________ DATE

______________________ WITNESS

______________________ PATIENT NAME (printed)

______________________ WITNESS NAME (printed)

****Please list current medications****

-If you brought a current list, please give it to the receptionist to copy and you can leave the space below blank.

Please list any known allergies:

CONSENT TO RECEIVE PHONE AND TEXT MESSAGES

By checking "yes" below, I hereby give my consent and permission to receive phone calls or text messages from Seymour Hospital Rural Health Clinic (or a third-party vendor acting on behalf of Seymour Hospital Rural Health Clinic) regarding billing and collection matters, or other important patient related matters, at any phone numbers which Seymour Hospital Rural Health Clinic has on file for me, and I understand that I may incur charges as a result of these calls or messages. I understand and agree that the phone calls or text messages may come from a human or from an autodialer and may be pre-recorded or artificial voice messages. I also expressly consent and agree that Seymour Hospital Rural Health Clinic (or a third-party vendor acting on behalf of Seymour Hospital Rural Health Clinic) may contact me by letter or by email, using any address or email address I have provided. I am freely giving my consent and I understand that my consent is not required as a condition of receiving services from Seymour Hospital Rural Health Clinic and that I may revoke my consent to receive phone calls or text messages at any time.

___ Yes   ___ No

______________________________   ____________________

Signed Name   Date

____

Printed Name

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Name of Patient: ______________________________

Date of Birth: ______________________________

I hereby authorize medical providers and personnel of Seymour Hospital and/or Seymour Rural Health Clinic to discuss my protected health information with:

(Name)____________________________ (Relationship)____________________

(Name)____________________________ (Relationship)____________________

(Name)____________________________ (Relationship)____________________

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

_____Information regarding the patient's diagnosis and treatment for HIV/AIDS
_____Psychotherapy notes from a Psychiatrist or Psychotherapist
_____Treatment for alcohol or drug abuse reports

This authorization shall be in force and in effect from _________ until _________ at which time this authorization to use or disclose this protected health information expires.

Unless specified above, this authorization will expire 365 days from the date of signing. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that such a revocation is not effective to the extent the Hospital has relied on the use or disclosure of the protected health information.

I understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization.

____________________________	____________________________	________
Signature of Patient/Personal Representative	**Name of Patient/Personal Representative**	**Date**

Representative's Authority to Act: ______________________