CENTERPOINT HEALTH REGISTRATION FORM

Please complete all sections

PATIENT INFORMATION

Last Name:	First Name:	MI:	Age:	Birth Date:	Social Security # _____-_____-_____	Gender (at birth): ☐ Male ☐ Female
Home Address: ☐ *Check if Homeless*			City:		State:	Zip Code:
Home Phone:	Cell Phone:			Email Address:		
May we leave you a voicemail message on the phone number(s) provided: ☐ Yes ☐ No						
Emergency Contact:	Relationship:			Primary Phone:		

RESPONSIBLE PARTY (*Required if patient is under the age of 18 or is an adult with a proxy/legal guardian.*)

Last Name:	First Name:	MI:	Birth Date:	Social Security # _____-_____-_____	Relationship:
Home/Billing Address:			City:	State:	Zip Code:
Home Phone:	Cell Phone:		Email Address:		

ADDITIONAL INFORMATION

Race (check all that apply): ☐ White/Caucasian ☐ African American/Black ☐ American Indian/Alaska Native ☐ More than One Race ☐ Native Hawaiian/Other Pacific Islander ☐ Asian	Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino
Language: ☐ English ☐ Spanish ☐ Other: _____	Gender Identity: ☐ Female ☐ Male ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female ☐ Decline to Answer ☐ Other: _____
I request translation services: ☐ Yes ☐ No	

Sexual Orientation	Marital Status:	How did you hear about us?	Do you have an Advance Directive or a Living Will? ☐ Yes ☐ No Do you have a DNR (Do Not Resuscitate)? ☐ Yes ☐ No
☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Don't Know ☐ Other: _____	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated	☐ Flyer ☐ Website ☐ WIC ☐ Billboard ☐ Referral ☐ Walk-in ☐ Radio ☐ Social Media ☐ Insurance Provider ☐ Friends/Family ☐ Other: _____	

CENTERPOINT HEALTH REGISTRATION FORM

Please complete all sections

Income and Dependents	
No. of Dependents (including Self) _____	Are you a Migratory/Seasonal Migratory Worker? ☐ Yes ☐ No
Annual Range – Check one box only	Are you a Veteran? ☐ Yes ☐ No
☐ None - $10,000.00 ☐ $10,001.00 - $15,000.00 ☐ $15,001.00 - $20,000.00 ☐ $20,001.00 - $25,000.00 ☐ $25,001.00 - $30,000.00	Are you disabled? ☐ Yes ☐ No
☐ $30,001.00 - $40,000.00 ☐ $40,001.00 - $50,000.00 ☐ $50,001.00 - $60,000.00 ☐ Over $60,000	

Do you have Medical Insurance? ☐ Yes ☐ No

Medical Insurance Provider: _____ Subscriber No: _____ Group No: _____

Name of Insured: _____ Insured's Employer: _____ Co Pay_____

Do you have Dental Insurance? ☐ Yes ☐ No

Dental Insurance Provider: _____ Subscriber No: _____ Group No: _____

Name of Insured: _____ Insured's Employer: _____ Co Pay_____

PERMISSION TO SHARE MY HEALTHCARE INFORMATION

In the course of your care, Centerpoint Health recognizes you may wish to involve certain family members, friends, and others to be involved by giving and receiving information about the care you received. In order to assist you, we ask that you identify those individuals, if any, in the space below. This does not authorize any copies of medical records, which will require a written patient authorization. This permission is in effect until it is revoked in writing to Centerpoint Health. You will need to provide an identifier to any individual to ensure the person calling has been given permission.

Name of Individual	Relationship to Patient

_____

Patient's Printed Legal Name

_____ _____

Signature of Patient or Responsible Party *Date*

Consent / Release Form

Authorization for Medical Treatment - Centerpoint Health and its Medical Staff are hereby authorized to administer any medical, diagnostic, or therapeutic treatment that may be determined necessary or advisable. I have the right to accept or refuse consent for any suggested procedure or course of treatment, except in emergency or extraordinary circumstances.

Disclosure of Information - I understand all medical records and billing information are made and retained by Centerpoint Health and are accessible to treatment staff. Clinical personnel and physicians may use and disclose medical information to any other health care personnel involved in the treatment continuum of care. Safeguards are in place to minimize improper access. Centerpoint Health is authorized to disclose any part of the medical record for the purpose of billing, including any insurance carrier, workers compensation carrier, or self-insured employer that may be liable for any part of the charges my treatment may incur as well as to any health care provider who is or may become involved in my care. The information used for disclosure may include information concerning communicable diseases. You consent to such disclosure.

Assignment of Insurance Benefits - I agree benefits for Centerpoint Health charges payable are to be made payable to Centerpoint Health for my care. Any payment received for this period may be applied to any unpaid bills for which I am responsible, subject to the rules of coordination of the benefits.

Financial Responsibility - In consideration for the services provided to me, payment is my responsibility and payment is guaranteed for any amount due for such services provided by Centerpoint Health. I agree to arrange for a payment plan with Centerpoint Health for any amounts due for services.

Operations - I understand that certain information about my care will need to be reviewed in order to process claims on my behalf by insurance or billing companies. In addition, certain funders and legal entities may be required to audit compliance or operations of Centerpoint Health to ensure that the services were rendered. They are required to protect the information reviewed and are subject to penalty for misuse.

Certification - I hereby acknowledge that I have read each of the above statements, have had each item explained to me to my satisfaction and understanding, and that I understand that I may receive a copy of this Consent/Release upon request. I further certify that I am the patient or am authorized by the patient to accept the terms of this Consent/Release. A photocopy of this document has the same effect as the original.

_____ _____

Printed Legal Name of Patient *Date*

_____ _____

Signature of Patient or Responsible Party *Relationship*

_____

Basis of Refusal, if refused

Delegated Consent for Treatment of Minors or Incapable Adults

This form allows a parent or legal guardian to designate other adults to bring the patient to Centerpoint Health for care.

Patient's Name: _____ Date of Birth: _____

I approve the individuals listed below to bring the patient to Centerpoint Health for treatment. Those listed can bring the patient to Centerpoint Health for the next year, unless I take their name off the list.

I understand Centerpoint Health requires the parent/guardian to be with the patient for some procedures.

Ohio law states both biological parents have the right to make healthcare decisions for a child. **If both biological parents are not present for this visit, list the absent parent below:**

Absent Parent: _____

Others that may bring the patient in:

Authorized Person	**Relationship**	**Phone Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Signature of Patient or Responsible Party *Relationship*

_____ _____
Staff Signature *Date*

Missed Appointment Contract

Patient Name: _____

I understand the following Centerpoint Policies:

Missed Appointment Policy: I understand if I miss three (3) appointments in a twelve (12) month period, my patient-physician relationship may be terminated.

Cancellation Policy: I understand if I do not call before the appointment, it will count as a no-show.

For these appointments:	**I need to cancel:**
Medical	2 hours before the appointment
Dental	24 hours before the appointment
Behavioral Health	24 hours before the appointment
Psychiatry	24 hours before the appointment

Appointment Confirmation Policy: I understand if I do not confirm my appointment prior to the day of the appointment, it will be cancelled.

I agree to follow the rules below to continue with the patient-physician relationship:

1. I will come to all scheduled appointments on time.
2. I will arrive for my appointment fifteen (15) minutes prior to the scheduled time to complete or update my registration information.
3. I will call two (2) hours prior to the scheduled time to cancel a medical appointment or twenty-four (24) hours prior to a dental, psychiatry, or behavioral health appointment.
4. Failure to comply with these rules will result in a note being placed in my chart for a no-show.
5. I understand that if I miss three (3) appointments in any twelve (12) month period that my patient-physician relationship may be terminated.

I have read and understand the rules listed above. I have had a chance to ask Centerpoint Health's staff any questions that I may have. I agree to follow these rules and understand the consequences of not doing so.

_____ _____

Signature of Patient or Responsible Party *Relationship*

_____ _____

Staff Signature *Date*

Patient's Rights and Responsibilities

As a patient, you have the right:

- To receive quality health care regardless of your age, sex, religion, nationality, sexual preference, disability, health status, or income status;
- To safe, considerate, and respectful care from all Centerpoint Health staff;
- To receive complete information about your diagnosis, treatment, and prognosis in a manner you can understand;
- To confidentiality of all information regarding to your care and medical conditions to the extent expected and permitted by law, including all records and communications;
- To have special needs met, such as an interpreter to help with communication;
- To be seen in a clean and safe environment;
- To make decisions and give instructions about your medical care in advance and to have them followed;
- To appoint a person to make health care decisions on your behalf in the event you are unable to make those decisions;
- To file a complaint about your care without fear of penalty and to have your complaint reviewed and, if possible, resolved.

As a patient, you have the responsibility:

- To provide, to the best of your knowledge, complete information about your symptoms, past illness, medications, and other matters relating to your plan of care;
- To schedule and keep appointments or call to cancel your appointment if you cannot be there, two hours prior for medical appointments and 24 hours prior for all other appointments;
- To notify Centerpoint Health of any changes in address, insurance, or family members;
- To provide a current copy of your insurance card and notify Centerpoint Health when there are changes in insurance coverage;
- To ask questions when you do not understand explanations about your care or services;
- To be responsible for your actions if you refuse treatment or do not follow your service provider's instructions;
- To be courteous and considerate to all Centerpoint Health staff and other patients.

_____ _____

Signature of Patient or Responsible Party *Date*

Release of Prescription Information
ePrescribe Program

ePrescribe is a way for your healthcare provider to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program includes:

- **Formulary and benefit transactions** give the health center provider information about which drugs are covered by your drug benefit plan.
- **Fill status notifications** allow the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication history transactions** provide the health care provider with information about potential medication and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate compliance with prescribed regimens, therapeutic interventions, drug-drug and drug-allergy interactions, adverse drug reactions, and duplicative therapy.

The medication history information can include medications prescribed by your health care provider at Centerpoint Health as well as other health care providers involved in your care. This information may reveal sensitive information including, but not limited to, medications related to a mental health condition, sexually transmitted diseases including HIV and AIDS, substance (drug and alcohol) abuse, and genetic diseases.

By signing this consent form, you are specifically informed and consent to have prescriptions transmitted electronically and know sensitive information about you may be revealed by the nature of the prescription. The receiving pharmacy is also required to protect this personal health information about you.

By signing this consent form, you agree your provider at Centerpoint Health may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. You may decline to sign this form. Your choice will not affect your ability to get health care, payment for health care, or your health care benefits. You also have a right to receive a copy of this form after you have signed it. This consent will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing; however, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide consent to Centerpoint Health to enroll myself in to the ePrescribe Program. I have complete understanding of the ePrescribe Program. All my questions about the program were answered to my satisfaction prior to giving my consent.

_____ _____

Printed Legal Name of Patient *Patient's Date of Birth*

_____ _____

Signature of Patient or Responsible Party *Date*

***RX Consent-** Patient's or Authorized Person's Consent: A code used to indicate whether the provider has a signed statement on file granting permission to view a patient's prescription history from external sources.*

Authorization for Release of Medical Information

To provide continuity of care, we will request your medical records from your previous primary care provider. This authorization form must be filled out completely in order for us to receive the records in a timely fashion and be able to continue with your care.

I hereby grant permission for the release of the following medical information relating to my care from and to the parties named below.

From: Dr./Office Name:
Street Address:
City, State, Zip:
Phone:
Fax:

To: Centerpoint Health
333 Conover Dr, Suites B and D
Franklin, OH 45005
Phone: 513-318-1188 Fax: 513-318-1189

_____ _____
Printed Legal Name of Patient (at time of treatment) *Patient's Date of Birth*

_____
Address of Patient *City, State, Zip Code*

_____ _____ _____
Patient's Social Security Number *Phone Number of Patient* *Dates of Treatment (mm/yy)*

Purpose of Request:

- ☐ Continuity of Care
- ☐ Legal Matter
- ☐ Insurance Claim
- ☐ Patient Request
- ☐ Other: _____

This information may include treatment of rehabilitation for drug and/or alcohol abuse, HIV Antibody Test (test for AIDS virus), psychiatric treatment, and related conditions, if they did occur. I specify this release is to include:

- ☐ Face Sheet
- ☐ Discharge Summary
- ☐ Laboratory Reports
- ☐ Radiological Reports
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ History & Physical Consultation
- ☐ Emergency Room Treatment
- ☐ Drug/Alcohol Abuse Treatment
- ☐ Mental Health Treatment

Other: _____

I understand the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. I understand this authorization is voluntary, and I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. I understand this authorization may be withdrawn at any time in writing, and this authorization expires 90 days after date of signature unless I specify an earlier expiration date.

_____ _____
Signature of Patient or Responsible Party *Date*

SLIDING FEE APPLICATION

Applicant's Name_____Today's Date_____

Address_____

City_____ State_____ Zip_____

Phone 1_____ Phone 2_____

Household and Income Worksheet

Determine the Number of People in Your Household:

Relationship	Include	Do Not Include	Number
Yourself			*1*
Your spouse	Include if you are legally married, regardless of sex. Include if you are legally married but living apart (for example, spouse is away on military duty, away on work, or away for some reason other than legally separated or divorced).	Do not include if you are legally separated or divorced. You do not need to claim your spouse if you are a victim of domestic abuse, domestic violence, or spousal abandonment.	
Child(ren)	Include number of dependent children. Include adopted and foster children, living with you that you can claim as a dependent. Include the number of children you with whom you share custody if you can claim them as a dependent. Include the number of children under 21 that you take care of.	Do not include if a child is a non-dependent. Do not include if a child is unborn.	
Other dependents:	Include the number of parents you claim as dependents. Include the number of siblings and other relatives who you claim as dependents.	Do not include unmarried domestic partner. Do not include roommates.	
Total Household Members (add right column)			

SLIDING FEE APPLICATION

Determine Your Household Income:

<table>
<tr><th>Income</th><th>Verification</th><th>Do Not Include</th><th>Amount</th></tr>
<tr><td>Wages, salaries, tips, etc.</td><td>Prior 4 weeks' pay stubs from all jobs x 12

<table><tr><th>Pay Frequency</th><th># of Stubs</th></tr><tr><td>Weekly</td><td>4</td></tr><tr><td>Bi-Weekly (every 2 weeks)</td><td>2</td></tr><tr><td>Semi-Monthly (1st and 15th)</td><td>2</td></tr><tr><td>Monthly</td><td>1</td></tr></table>
Most recent Form 1040 Line 22, most recent W2s box 1, most recent 1099s (for self-employed)</td><td>Any information more than 2 months old</td><td></td></tr>
<tr><td>Alimony</td><td>Most recent month's check stubs x 12</td><td>Any information more than 2 months old</td><td></td></tr>
<tr><td>Unemployment compensation</td><td>Most recent month's check stubs x 12</td><td>Any information more than 2 months old</td><td></td></tr>
<tr><td>Social Security benefits</td><td>Most recent month's check stubs x 12</td><td>Any information more than 2 months old</td><td></td></tr>
<tr><td>IRA or retirement plan distributions</td><td>Most recent month's check stubs x 12</td><td>Any information more than 2 months old</td><td></td></tr>
<tr><td>Interest, dividends, rental income</td><td>From most recent Form 1040</td><td></td><td></td></tr>
<tr><td>Business Income</td><td>Most recent Form 1040</td><td></td><td></td></tr>
<tr><td>Capital gains</td><td>Most recent Form 1040</td><td></td><td></td></tr>
<tr><td>Other</td><td></td><td></td><td></td></tr>
<tr><td colspan="3">Total Income (add right column)</td><td></td></tr>
</table>

Documentation of No Income: If you report $0 income, please explain below how you are surviving without income:

_____

_____

_____ _____

Signature of Patient or Responsible Party *Signature of CPH Witness*

SLIDING FEE APPLICATION

Certification:

I certify that the household size and income information above is correct. **I understand that documentation supporting my household financial position is required before my discount can be approved and that I must provide this information within 30 days or prior to my next visit if sooner.**

I understand I must update this information if my situation changes and a new Sliding Fee Application must be completed at least every 12 months. I have received information explaining the program, and I understand and agree to abide by the terms. I understand if I am a self-pay patient, I will be responsible to pay at least a minimum of $20 for healthcare services. If an unpaid balance exists on my account after applying my sliding fee discount, I agree to contact CPH, make payment arrangements, and honor the terms.

Patient Name (print)_____

Signature of Patient or Guarantor_____

Date of Signature_____

CPH USE ONLY:

Application Reviewed by_____Date_____

If no proof of income is provided, the CEO, CFO, or their Designee must sign off for approval to use the sliding fee:

CEO, CFO, or Designee Signature: _____Date_____