



CENTERPOINT HEALTH REGISTRATION FORM

Please complete all sections

PATIENT INFORMATION

Last Name:	First Name:	MI:	Age:	Birth Date:	Social Security # ____-____-____	Gender (at birth): <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address: <input type="checkbox"/> <i>Check if Homeless</i>			City:		State:	Zip Code:
Home Phone:	Cell Phone:		Email Address:			
May we leave you a voicemail message on the phone number(s) provided: <input type="checkbox"/> Yes <input type="checkbox"/> 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): <input type="checkbox"/> White/Caucasian <input type="checkbox"/> African American/Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> More than One Race <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Asian			Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino
Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Male/Female-to-Male <input type="checkbox"/> Transgender Female/Male-to-Female <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Other: _____	
I request translation services: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Sexual Orientation <input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Don't Know <input type="checkbox"/> Other: _____	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated	How did you hear about us? <input type="checkbox"/> Flyer <input type="checkbox"/> Website <input type="checkbox"/> WIC <input type="checkbox"/> Billboard <input type="checkbox"/> Referral <input type="checkbox"/> Walk-in <input type="checkbox"/> Radio <input type="checkbox"/> Social Media <input type="checkbox"/> Insurance Provider <input type="checkbox"/> Friends/Family <input type="checkbox"/> Other: _____	Do you have an Advance Directive or a Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a DNR (Do Not Resuscitate)? <input type="checkbox"/> Yes <input type="checkbox"/> No



CENTERPOINT HEALTH REGISTRATION FORM

Please complete all sections

<p style="text-align: center;"><u>Income and Dependents</u></p> <p>No. of Dependents (including Self) _____</p> <p style="text-align: center;"><u>Annual Range – Check one box only</u></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> None - \$10,000.00</td> <td style="width: 50%; border: none;"><input type="checkbox"/> \$30,001.00 - \$40,000.00</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> \$10,001.00 - \$15,000.00</td> <td style="border: none;"><input type="checkbox"/> \$40,001.00 - \$50,000.00</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> \$15,001.00 - \$20,000.00</td> <td style="border: none;"><input type="checkbox"/> \$50,001.00 - \$60,000.00</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> \$20,001.00 - \$25,000.00</td> <td style="border: none;"><input type="checkbox"/> Over \$60,000</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> \$25,001.00 - \$30,000.00</td> <td style="border: none;"></td> </tr> </table>	<input type="checkbox"/> None - \$10,000.00	<input type="checkbox"/> \$30,001.00 - \$40,000.00	<input type="checkbox"/> \$10,001.00 - \$15,000.00	<input type="checkbox"/> \$40,001.00 - \$50,000.00	<input type="checkbox"/> \$15,001.00 - \$20,000.00	<input type="checkbox"/> \$50,001.00 - \$60,000.00	<input type="checkbox"/> \$20,001.00 - \$25,000.00	<input type="checkbox"/> Over \$60,000	<input type="checkbox"/> \$25,001.00 - \$30,000.00		<p>Are you a Migratory/Seasonal Migratory Worker? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<input type="checkbox"/> None - \$10,000.00	<input type="checkbox"/> \$30,001.00 - \$40,000.00										
<input type="checkbox"/> \$10,001.00 - \$15,000.00	<input type="checkbox"/> \$40,001.00 - \$50,000.00										
<input type="checkbox"/> \$15,001.00 - \$20,000.00	<input type="checkbox"/> \$50,001.00 - \$60,000.00										
<input type="checkbox"/> \$20,001.00 - \$25,000.00	<input type="checkbox"/> Over \$60,000										
<input type="checkbox"/> \$25,001.00 - \$30,000.00											

<p>Do you have Medical Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
Medical Insurance Provider: _____ Name of Insured: _____	Subscriber No: _____ Insured's Employer: _____	Group No: _____ Co Pay _____	
<p>Do you have Dental Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
Dental Insurance Provider: _____ Name of Insured: _____	Subscriber No: _____ Insured's Employer: _____	Group No: _____ 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

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

From:

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:

- | | |
|---|--|
| <input type="checkbox"/> Continuity of Care | <input type="checkbox"/> Patient Request |
| <input type="checkbox"/> Legal Matter | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Insurance Claim | |

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 | Laboratory Reports | History & Physical Consultation |
| Discharge Summary | Radiological Reports | Emergency Room Treatment |
| | Operative Reports | Drug/Alcohol Abuse Treatment |
| | Pathology Reports | 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	<p>Include if you are legally married, regardless of sex.</p> <p>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).</p>	<p>Do not include if you are legally separated or divorced.</p> <p>You do not need to claim your spouse if you are a victim of domestic abuse, domestic violence, or spousal abandonment.</p>	
Child(ren)	<p>Include number of dependent children.</p> <p>Include adopted and foster children, living with you that you can claim as a dependent.</p> <p>Include the number of children you with whom you share custody if you can claim them as a dependent.</p> <p>Include the number of children under 21 that you take care of.</p>	<p>Do not include if a child is a non-dependent.</p> <p>Do not include if a child is unborn.</p>	
Other dependents:	<p>Include the number of parents you claim as dependents.</p> <p>Include the number of siblings and other relatives who you claim as dependents.</p>	<p>Do not include unmarried domestic partner.</p> <p>Do not include roommates.</p>	
Total Household Members (add right column)			



SLIDING FEE APPLICATION

Determine Your Household Income:

Income	Verification	Do Not Include	Amount										
Wages, salaries, tips, etc.	Prior 4 weeks' pay stubs from all jobs x 12 <table border="1" data-bbox="456 489 915 743"> <thead> <tr> <th>Pay Frequency</th> <th># of Stubs</th> </tr> </thead> <tbody> <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> </tbody> </table> Most recent Form 1040 Line 22, most recent W2s box 1, most recent 1099s (for self-employed)	Pay Frequency	# of Stubs	Weekly	4	Bi-Weekly (every 2 weeks)	2	Semi-Monthly (1 st and 15 th)	2	Monthly	1	Any information more than 2 months old	
Pay Frequency	# of Stubs												
Weekly	4												
Bi-Weekly (every 2 weeks)	2												
Semi-Monthly (1 st and 15 th)	2												
Monthly	1												
Alimony	Most recent month's check stubs x 12	Any information more than 2 months old											
Unemployment compensation	Most recent month's check stubs x 12	Any information more than 2 months old											
Social Security benefits	Most recent month's check stubs x 12	Any information more than 2 months old											
IRA or retirement plan distributions	Most recent month's check stubs x 12	Any information more than 2 months old											
Interest, dividends, rental income	From most recent Form 1040												
Business Income	Most recent Form 1040												
Capital gains	Most recent Form 1040												
Other													
Total Income (add right column)													

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 _____