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:	Social Security # ____-_____-_____	Birth Date:	Primary phone:	Relationship:
Mailing/Billing Address:	City:	State:	Zip Code:	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
☐ Heterosexual
☐ Homosexual
☐ Bisexual
☐ Don't Know
☐ Other: _____

Marital Status:
☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Legally Separated

How did you hear about us?
☐ Flyer
☐ WIC
☐ Referral
☐ Insurance Provider
☐ Bench Ad
☐ Other: _____

Do you have an Advance Directive or a Living Will? ☐ Yes ☐ No

Do you have a DNR (Do Not Resuscitate)? ☐ Yes ☐ No

Income and Dependents

No. of Dependents (including Self) _____

Annual Range – Check one box only

☐ 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
☐ $30,001.00 - $40,000.00
☐ $40,001.00 - $50,000.00
☐ $50,001.00 - $60,000.00
☐ Over $60,000

Are you a Migratory/Seasonal Migratory Worker? ☐ Yes ☐ No

Are you a Veteran? ☐ Yes ☐ No

Are you a Disabled? ☐ Yes ☐ No

Do you have insurance? ☐ Yes ☐ No

Primary Insurance Provider: _____ Subscriber No: _____ Group No: _____
Name of insured: _____ Insureds Employer: _____ Co Pay_____
Secondary Insurance Provider: _____ Subscriber No: _____ Group No: _____
Name of insured: _____ Insureds Employer: _____ Co Pay_____

PERMISSION TO SHARE MY HEALTHCARE INFORMATION

In the course of your care, Centerpoint Health recognizes that 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 any 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 that the person calling is someone you give permission to speak to.

Name of Individual	**Relationship to Patient**	**Identifier**

Responsible Party Signature _____ 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, with the exception of emergency or extraordinary circumstances.

Disclosure of Information - I understand that 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. This information used for disclosure may include information concerning communicable diseases, you are consenting 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 authorized by the patient to accept the terms of this Consent/Release. A photocopy of this document has the same effect as the original.

_____ _____ _____

Patient/Responsible Party Signature Date Relationship

Basis of refusal, if refused: _____

***HCFA Field 12**: Patient's or Authorized Person's Signature – A code used to indicate whether the provider has a signed statement on file permitting the release of medical data to other organizations in order to adjudicate claims.*

GENERAL CONSENT TO TREAT

I understand that it is my responsibility to provide complete and accurate information on this form. I attest the above information is correct to the best of my knowledge. I understand that failure to provide correct information on this form may result in my being responsible for all charges. I consent to any services rendered to me and my dependents by the Centerpoint Health medical staff. I request payment of insurance benefits to Centerpoint Health. I understand and agree that, regardless of by insurance benefits, I am responsible for any outstanding balances with Centerpoint Health for services rendered and fees associated with my treatment.

Patient or Parent/Guardian Signature:	**Date:**

Delegated Consent
For Treatment of Minors
Or Incapable Adults

This form allows a parent or legal guardian to designate another adult(s) to bring the patient in for care.

Patient's Name: _____

Patient's Date of Birth: _____

I approve the individuals listed below to bring the patient to Centerpoint Health for treatment. This person(s) can bring the patient in for the next year, unless I take their name off the list.

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

Ohio laws state that both biological parents have the right to make healthcare decisions for a child. **If both biological parents are not present for this visit, write the absent parent's name here:**

_____

Others that may bring the patient in:

Authorized Person	Relationship	Phone Number
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

_____ _____
Parent/Patient Representative Signature Date

_____ _____
Staff Signature Date

Missed Appointment Contract

Patient Name: _____

I understand that Centerpoint Health has a policy that if I miss three (3) appointments in a twelve (12) month period that my patient-physician relationship may be terminated. I further understand that if I do not call to cancel my medical appointment two (2) hours prior to the scheduled time, it will count as a no-show. I understand that if I do not call to cancel my dental appointment twenty-four (24) hours prior to the scheduled time, it will count as a no-show. If I have a counseling appointment with the behavioral health team, this requires twenty-four (24) hours' notice or this will be considered a no-show. If I have a Psychiatry appointment, this requires twenty-four (24) hours' notice or this will be considered a no-show. I understand that if I do not confirm my appointment prior to the day of, 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 doctor's 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 for medical. And I will call twenty-four (24) hours prior to a dental appointment or a counseling appointment with behavioral health. Failure to comply with this rule will result in a note being placed in my chart for a no-show.

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.

_____

Patient or Representative's Signature

_____ _____

Witness/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 I 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 appoint a person to make health care decisions on your behalf in the event that you are unable to do so
- To make decisions and give instructions about your medical care in advance, and to have them followed
- To file a complaint about your care without fear of penalty and to have your complaint reviewed and, if possible, resolved

Your responsibilities as a patient:

- 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 doctor appointments, or call to cancel your appointment if you cannot be there, 24 hours prior
- To notify Centerpoint Health of any changes in address, insurance, or family members
- To Provide a current copy of 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: _____ **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 also includes:

- **Formulary and benefit transactions-** Gives the health center provider information about which drugs are covered by your drug benefit plan.
- **Fill status notification-** Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been pick up, not picked up, or partially filled.
- **Medication history transaction-** Provides 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 include 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 are consenting to have prescriptions transmitted electronically and that 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 patients.**

Consent

By signing this consent form, you are agreeing that 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 of my questions about the program were answered to my satisfaction prior to giving my consent.

Patient Name: _____ Patient's D.O.B. _____

Patient/Guardian Signature: _____ 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.*

333 Conover Drive
Suites B & D
Franklin, OH 45005

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 & D

Franklin, Ohio 45005

The purpose of this request is for:

□ Continuity of Care □ Legal matter □ Other (specify) _____

□ Insurance Claim □ At the request of the individual

_____ _____

Patient's Name Date of Birth

_____ _____

Name at time of treatment Social Security Number

_____ _____

Patient's Address Telephone Number

Date (s) of treatment: (MM/YY) _____

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

□ Face Sheet □ Laboratory report □ Mental Health treatment

□ Discharge Summary □ Radiological reports □ Other specified here:

□ History & Physical □ Operative reports _____

□ Consultation □ Pathology Reports _____

□ Emergency Room Treatment _____

□ Drug/Alcohol abuse treatment

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

_____ _____

Date Signature of patient/patient's representative

Centerpoint HEALTH

SLIDING FEE APPLICATION

Applicants 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)			

Determine Your Household Income

Income	*Verification*	*Do Not Include*	Amount
Wages, salaries, tips, etc.	Prior 4 weeks' pay stubs from all jobs x 12 **Pay Frequency** / **# of Stubs** Weekly: 4 Bi-Weekly (every 2 weeks): 2 Semi-Monthly (1st and 15th): 2 Monthly: 1 Most recent Form 1040 Line 22, most recent W2s box 1, most recent 1099s (for self-employed)	Any information more than 2 months old	
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:

Patient's Signature:_____ CPH Witness:_____

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 that I must update this information if my situation changes and that 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 that 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 and 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, CEO, CFO or their Designee must sign off for approval to use the sliding fee:

CEO, CFO or Designee Signature:_____Date_____