Southwest Ohio Health Partners Patient Registration and History Questionnaire

Name: _____ Age: _____ Date of Birth: _____ Date: _____
Last First Middle

Address: _____ City: _____ State:____ Zip Code: _____

Social Security #: _____ ☐ Male ☐ Female Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children: _____

Home Phone (____) _____ Work Phone (____) _____

Cell Phone (____) _____ E-mail Address: _____

Employer: _____ Spouse's Name: _____

Occupation: _____ Spouse's Employer: _____

Insurance: _____ Subscriber name :_____

Relationship to subscriber: _____ Subscriber DOB: _____

Who referred you to this office? _____

In case of emergency, notify_____ **Relationship** _____ **Phone** (____) _____

Chief Complaint or Reason for Office Visit: _____

Specific Date and Time of Onset of Symptoms: _____

What makes your symptoms better? _____ What makes your symptoms worse? _____

What is the quality of your symptoms? (ache, burn, dull, sharp, throbbing):_____

Are your symptoms local or do they travel to another area? (If they travel, to where?)_____

Are symptoms; ☐ Constant >76% ☐ Frequent 51-75% ☐ Occasional 26-50% ☐ Intermittent <25% **of your waking hours**

Please list all medications and dosage:	**Frequency**	**For what Illness?**

List any allergies to medications, foods or other (if none, write none)_____

Are you pregnant? ☐ **Yes** ☐ **No**

Do you smoke? ☐ Yes ☐ No: How much? _____ Do you drink alcohol? ☐ Yes ☐ No; How much_____

Please list all serious illnesses, surgeries and serious accidents:	**Month and Year**	**City, State**

Please list any recent x-rays, lab or other tests:	**Date**	**Facility/Doctor**

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES? Check (√) all that apply.

☐ Tuberculosis	☐ Heart Disease	☐ Colon Disease	☐ Arthritis
☐ Lung Disease	☐ Hepatitis	☐ Stroke	☐ Asthma
☐ Gout	☐ Sciatica	☐ Cancer	☐ Anemia
☐ Diabetes	☐ Blood Pressure	☐ Bleeding	☐ Thyroid Disease
☐ Kidney Disease	☐ Transfusion	☐ Paralysis	☐ Drug Dependence
☐ Stomach/Ulcer	☐ Polio / MS	☐ Seizures	☐ AIDS

Southwest Ohio Health Partners
5740 Gateway Blvd., Suite 103
Mason, OH 45040
(513) 229-7333 Fax (513) 492-9475

For the remainder of this action manual, the above practice name will be called "Clinic".

This notice describes how your private health information at the Clinic may be used or disclosed.
Review this information carefully.

Clinic is required by law, to maintain the privacy and confidentiality of your protected health information and to provide you, our patient, with a notice of our legal duties and privacy practices with respect to your protected health information.

Clinic notice of privacy agreement definitions:

Patient, you or your shall mean the same as the person named below:

_____
(Patient Name)

Clinic shall mean the same as the above clinic's name.
Privacy rule shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E of the 1996 HIPPA.
Clinic notice of privacy agreement shall mean the same as Agreement meaning this specific agreement.
Notice shall mean the same as Clinic notice of privacy agreement also meaning this specific agreement.

Disclosure of your protected Health Care Information:

Treatment Records:

1. Your private health information may be used in the Clinic by all Clinic doctors for the purpose of treating you on a day-to-day basis.
2. If we need to refer you to another doctor outside the Clinic it may be necessary to provide them with your protected health information.
3. From time to time a substitute doctor of the Clinic's choosing may treat you. In those instances your protected health information would be shared with that doctor without advance permission or notice. This could happen if your treating doctor is sick, or unavailable, or on vacation, or other emergencies.

Patient Payment Records:

1. In order to get your bill paid, we will disclose your private health information as is required by your insurance companies to get your bill paid at the clinic. Included in this information will be a diagnosis of your condition, treatment dates, injury or health condition dates of onset, and specific billing codes that describe the type of care you received at this Clinic.
2. If you are a Worker's Compensation patient by law the Clinic must disclose any of your private health information.

Emergencies:

In the event there is an emergency that involves you, the clinic may disclose your private Health Information to a Family member or your legal guardian. This may include your medical emergency condition or death

Public Health Officials:

The law requires that the Clinic must disclose your protected Health information to public officials in the following situations:.

1. In the prevention or controlling communicable diseases.
2. Reporting suspected domestic violence or child abuse and neglect.
3. Reaction to prescribed drugs to the food and drug administration.
4. Judicial proceedings; judges.
5. Law enforcement agencies that deal with locating fugitives, witnesses or missing persons. Complying with a court order or a subpoena.
6. Coroners or medical examiners.
7. Organization involved in getting or banking transplant organs, if you die.

8. Research required by law to report in association with the Institutional Review Board.
9. Public Safety Officials, in instances where the public health or safety may be jeopardized.
10. Special government agencies such as the military, national security or prison authorities.
11. Clinic sale, if the practice is sold to another doctor your private information becomes the property and the responsibility of the new owner.

Your rights as described in the HIPAA Act:

You have the right to put certain restrictions on how the Clinic uses and discloses your private health information. The Clinic does not have to agree to the restriction in certain situations.

You have the right to have the Clinic send all mail to you at a different address than where you live. You must request this.

You have the right to look at all your health information files that the Clinic has.

You have the right to get a copy of any of your health information.

You have the right to request a change in any of the chart notes or information in your health information files. The Clinic can by law not comply with your requested change to health information. The Clinic however, must give you a written response as to why it does not want to change your health information record. Also the Clinic will tell you how you can disagree with the denial.

You have the right to have the Clinic show you all the people or places that your protected health information has been sent to.

You have the right to have a copy made of this Notice of Privacy Practices at anytime you ask for it.

Further changes to this notice of privacy agreement:

Clinic can change this notice at any time. This notice will continue to be in force until new changes have been made. Any time changes are made to this notice, Clinic is required by law to have you sign a new copy and then give you a copy.

If you have any questions about this notice or any questions about your protected health information, please discuss this with the clinics security officer. Feel free to call our clinic at the number mentioned at the top of this agreement and make an appointment to discuss this notice. We will make an appointment for you for a personal phone call or in person conference within two working days.

Complaints about the Clinics privacy policies or procedures:

Any complaint about how the clinic has handled your private health information should be directed to the clinics Privacy officer. You can call the Clinic at the above phone number and the Clinic will make an appointment with you to discuss your concerns within two working days. If you are not satisfied with how the clinic handles your complaint you can send a formal complaint to:

Office for Civil Rights
U.S. Department of Health & Human Services
50 United Nations Plaza – Room 322
San Francisco, CA 94102

Patient Complaints may be voiced to Ohio Department of Health at 800-669-3534

Restrictions or changes of your private health information or changes of mailing address or phone number, fax number, or e-mail. If you wish to:

Request for a restriction of your protected health information
Change where the clinic sends your mail
Change where the clinic communicates to you by phone, fax, or e-mail
Wish to object about the Notice of Privacy Agreement

Simply ask any of our clinic employees for the form to do so.

Retention and storage of treatment records:

By law the Clinic is required to retain any original copies of medical records of adults for at least six years after the last date an adult patient receives medical or healthcare services and if the patient is a child the Clinic must retain records for at least three years after the child's eighteenth birthday or six years after the last date the child receives services, whichever occurs later.

Records may be destroyed, after the appropriate time has passed, without any treatment activity.

All records are maintained at the Clinic located at 5740 Gateway Blvd., Suite 103, Mason, OH 45040.
All requests for copies of treatment records should be directed to this office.

In the event the Clinic is sold; original treatment records will remain with the practice. Patient will be notified of the ownership change and directed as to how they can request copies of their treatment.

In the event the clinic is closed; records will be moved to a secure storage facility. Patients will be notified and directed as to how they can request copies of their treatment records.

As required by the privacy regulations, I hereby that this is the most current copy of the Clinics "Notice of Privacy Agreement" with the current revision Date of December, 2018.

☐ I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the Clinic with my authorization and consent to use and disclose my protected Health Care Information for the purpose of treatment, payment, and health care operations as described in the Privacy Notice.

Patient's Name (print)

Patient's Signature Date

Authorized Facility Signature Date

☐ I have read the Privacy Notice and understand my rights contained in this notice. However I do not agree to the above notice. Therefore I will not sign above. My signature below this line indicates that I do not agree to this notice, however I have received a copy of this notice as required by law.

Patient's Name (print)

Patient's Signature Date

Authorized Facility Signature Date

*Keep a copy in patient's file

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MEDICAL TREATMENT AGREEMENT

Patient or someone acting for the patient agrees to the following terms for patient care:

1. MEDICAL TREATMENT: Patient will be treated by his/her attending doctor or specialist. Patient authorizes SWOHP to perform services ordered by the doctors. Special consent forms may be needed. Many doctors and assistants (such as those providing x-rays, lab tests, and anesthesiology) may not be SWOHP employees and are responsible for their own treatment activities. Patient consents to the treatment to be provided by those doctors and technicians. SWOHP may develop and establish certain criteria which will automatically trigger the performance of special tests which patient agrees may be performed without any further separate consent.
2. GENERAL DUTY NURSING: SWOHP provides only general nursing care. If the patient needs special or private nursing, it must be arranged by the patient or by the doctor treating the patient.
3. MONEY AND VALUABLES: SWOHP will not be responsible for any loss or damage to items. SWOHP will not be responsible for loss or damage to items such as glasses, dentures, hearing aids and contact lenses.
4. RELEASE OF INFORMATION: SWOHP or a treating provider may disclose all or any part of the patient's medical and/or financial records (INCLUDING INFORMATION REGARDING ALCOHOL OR DRUG ABUSE, OR CONFIDENTIAL COMMUNICABLE DISEASE RELATED INFORMATION), to the following:
   a.) THIRD PARTIES: Including but not limited to any person or corporation, or their designee, which may be liable under contract to SWOHP any other party, the patient, a family member, or employee of the patient, for medical payment of all or part of a provider's charges, such as insurance companies, worker's compensation payers. SWOHP or medical service companies, welfare funds, governmental agencies or the patient's employer; quality assurance and peer review committees, subcommittees, ad hoc committees, or consultants; utilization review organizations; Medicare review organizations; SWOHP accrediting surveyors; treating physicians; and SWOHP and treating physicians professional liability insurance carriers.
   b.) OTHER HEALTH CARE PROVIDERS: Information may be released to other health care providers in order to provide continued patient care.

   I understand the authorization granted in items 4, a and b may be revoked by me at any time, except to the extent to which action has been taken in reliance upon it. The authorization will stay in effect as long as the need for information in items 4, a and b exists.

I have read and understand this Admissions Agreement, have received a copy and I am the patient, the parent of a minor child or the court appointed guardian for the patient. I am authorized to act on the patient's behalf to sign this Agreement.

_____ _____

Witness Patient Parent of Minor Child Court Appointed Guardian
(Please circle correct title)

_____

Date Time

MEDICAL POWER OF ATTORNEY, I appoint: _____

_____ _____

Address Phone

as my agent to act in all manners relating to my health care, including full power to give or refuse consent to all medical, surgical and SWOHP care. This power of attorney shall be effective upon my disability or incapacity or when there is uncertainty whether I am dead or alive and shall have the same effect as if I were alive, competent to act for myself.

_____ _____

Witness Patient

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FINANCIAL AGREEMENT

I agree that in return for the services provided to the patient by SWOHP or other health care providers, I will pay the account of the patient, and/or prior to discharge make financial arrangements satisfactory to or any other providers for payment. If an account is sent to an attorney for collection, I agree to pay reasonable attorney's fees and collection expenses. The amount of the attorney's fee shall be established by the Court and not by a jury in any court action. A delinquent account may be charged interest at the legal rate. If an account is sent to an agency for collection, I agree to pay collection fees, equating up to 50% of the outstanding balance at the time the account is placed with the agency.

I understand that my health insurance is a contract between me and the insurance carrier and the provider. I understand that I am ultimately responsible for any fees rendered to me that are not covered by my insurance company. I agree to pay my portion of fees at the time treatment is rendered by SWOHP. This office accepts billing for individual or group policies, personal injury claims and authorized worker's compensation.

I agree that SWOHP shall be appointed as my agent to endorse drafts or any checks for payment of my bill for medical services rendered.

When paying by check towards any amount that may be due by the patient, I understand that if the check is returned unpaid, the checking account will be debited electronically for both the face amount on the check and a $25.00 service charge. This will be in addition to any charges assessed by my financial institution as a result of the dishonored check.

If any signer is entitled to benefits of any type whatsoever under any policy of insurance insuring any patient, or any other party liable to patient, that benefit is hereby assigned to SWOHP or to the provider group rendering services for application on patient's bill. HOWEVER, IT IS UNDERSTOOD THAT THE UNDERSIGNED AND PATIENT ARE PRIMARILY RESPONSIBLE FOR PAYMENT OF PATIENT'S BILL.

IN GRANTING ADMISSION OR RENDERING TREATMENT, SWOHP AND OTHER PROVIDERS ARE RELYING ON MY AGREMENT TO PAY THE ACCOUNT. EMERGENCY CARE WILL BE PROVIDED WITHOUT REGARD TO THE ABILITY TO PAY.

_____	_____
Patient	Other Party Agreeing To Pay
_____	_____
Witness	Relationship To Patient
_____	
Date	

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I, _____, authorize **Southwest Ohio Health Partners**, Tricia Croake-Uleman, M.D., any other doctor, facility or representative of **Southwest Ohio Health Partners** to discuss/provide medical treatment to me, in the presence of:

- _____
- _____
- _____

Without my being present.

_____
Printed Name

_____ _____
Signature Date

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(513) 229-7333

Patient Consent to Leave Detailed Message/Information

Dear Patient:

Southwest Ohio Health Partners Physicians has adopted a policy that requires our staff to obtain authorization from the patient to leave detailed messages for the patient. This policy is to protect the patient and to also protect our staff from violating the patient's confidentiality. If we do not have a signed consent on file, the staff may only leave their name and a phone number on an answering machine or with another person answering your phone.

By completing the consent below, you hereby authorize the staff to call and leave their name, doctor's name, and additional information on an answering machine or with a specific individual. Unless notified in writing, this consent will remain in effect permanently.

☐ I give consent to my doctor and/or staff of Southwest Ohio Health Partners Physicians to leave a message regarding treatment, test results or other necessary information.

Please print phone numbers on line(s)

1. _____ Home Phone on answering machine at home
2. _____ Cell Phone on cell phone voice mail
3. _____ Work Phone on voice mail at work

Patient Signature: _____ Date: _____

☐ I do **NOT** consent to any messages being left on my machine other than office name and phone number.

Patient Signature: _____ Date: _____

MEDICAL RECORDS REQUEST AND RELEASE

Last Name _____ First Name _____ Initial _____ Date of Birth _____

Street _____ City _____ State _____ Zip Code _____

I, the undersigned, hereby authorize _____
(Health Services Provider/Physician)

to provide from my medical record the information specified below to Southwest Ohio Health Partners for the purpose of medical treatment.

I understand that the **entire** medical record, including information pertaining to drug or alcohol abuse and psychological or psychiatric treatment, will be provided unless I specify that the following information should not be released:

_____

_____

_____

Release or transfer of the specified information to any person or entity not specified herein is prohibited. An additional written consent must be obtained for a proposed new use of the information or for its transfer to another person or entity.

This authorization shall be valid until _____
Date

I understand that I have a right to receive a copy of this authorization upon my request.

Copy requested and received ☐ Yes ☐ No

Patient's Signature: _____ Date: _____

or Personal Representative: _____

Request Received By: _____ Date: _____