

Hedges Clinic

Patient Registration Form

Patient Information:

Today's Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Social Security Number: _____ Sex: M F

Address: _____
ADDRESS CITY STATE ZIP

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail Address: _____

Preferred Method of Communication: Home Number Cell Number Other: _____

Marital Status: Single Married Other: _____ Employment Status: FT PT Retired Student N/A

If minor, who is responsible party? _____

Emergency Contact: _____ Relationship: _____
NAME PHONE NUMBER

Do we have permission to contact this person regarding matters concerning your care? Yes No

Preferred Pharmacy: _____ Mail Order? Yes No
NAME ADDRESS PHONE NUMBER

Ethnicity (check one):

- Non-Hispanic
- Hispanic
- Refused to Report

Primary race (check one):

- White
- Hispanic
- African American/Black

- Asian
- Native American
- Native Hawaiian

- Other Pacific Islander
- Other Race
- Unreported/Refused

Preferred Language (check one): English Spanish Other: _____

Do you have an advanced directive such as a living will or medical power of attorney? Yes No

Is your visit with us today due to an automobile accident or work place accident? Yes No

Have any other member of your household been to this office? Yes No

If yes please list names: _____

Responsible Party (Guarantor):

Name: _____ Date of Birth: _____ Social Security Number: _____

Address: _____
ADDRESS CITY STATE ZIP

Employer: _____ Employer Address: _____
ADDRESS CITY STATE

Home Phone: _____ Cell Phone: _____ Work: _____

Relationship to Patient: _____ Employment Status: FT PT Retired Student N/A

ELECTRONIC PRESCRIPTIONS: *Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing this, you authorize us to do so.*

IMMUNIZATIONS: *Our electronic medical record program allows for your immunization data to be sent directly to the I-CARE State of Illinois Registry. I-CARE allows your providers to obtain your immunization history to ensure your safety. By signing this, you authorize us to submit this data.*

Signature: _____ Date: _____
PATIENT/GUARDIAN RELATIONSHIP TO PATIENT

Hedges Clinic, S.C.
222 Colorado Ave
Frankfort, Illinois 60423
815-469-2123

Patient Name: _____

Date of Birth: _____

****SIGNATURE OF THIS FORM DOES NOT RELIEVE PATIENT OF THE RESPONSIBILITY TO PROVIDE HEDGES CLINIC WITH ACTUAL INSURANCE CARDS OR DOCUMENTATION****

ASSIGNMENT TO PAY BENEFITS TO PHYSICIAN:

I hereby assign payment by my insurance company (or third party who might be responsible for paying medical services) directly to Hedges Clinic, S.C. of Frankfort, Illinois. I agree to be responsible to Hedges Clinic; S.C. for charges not covered by this assignment, and hereby authorize Hedges Clinic, S.C. to obtain my credit report from any or all of the credit reporting agencies. I agree to be liable for any charges not paid by my insurance company that were incurred by children or dependents of mine over the age of eighteen years who are listed or covered under my health insurance. I furthermore agree to be liable for reasonable attorney fees and court costs incurred by the medical provider and agree that the proper venue for any legal action is Will County, Illinois in the event I fail to pay the amounts due for services rendered and this account is sent to any attorney for collection.

Signature: _____ Date: _____
PATIENT/GUARDIAN RELATIONSHIP TO PATIENT

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Hedges Clinic S.C., to release any information acquired in the course of examination or treatment to my insurance company (or third party who may be responsible for payment of medical services).

Signature: _____ Date: _____
PATIENT/GUARDIAN RELATIONSHIP TO PATIENT

Hedges Clinic, S.C.
222 Colorado Ave
Frankfort, Illinois 60423
815-469-2123

**CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION AND RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

I, _____, hereby give my consent to *Hedges Clinic, S.C.* to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____.

PATIENT NAME

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available at the Hedges Clinic S.C. reception desk.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signature: _____ Date: _____
PATIENT/GUARDIAN RELATIONSHIP TO PATIENT

Consent Form Definitions

“Health care operations” refers to a large number of activities, including:

1. Conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under the supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;
3. Underwriting, premium rating, and other activities related to creation, renewal, or replacement of contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
5. Business planning and development, such as conducting cost management and planning related analyses related to operating the entity, including formulary development and administration, development or improvement methods of payment or coverage policies; and
6. Business management and general administrative activities including but not limited to: (a) management activities related to HIPAA privacy rule compliance; (b) customer services, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer; (c) resolution of internal grievances; (d) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity; and (e) creating de-identified health information, fundraising for the benefit of the covered entity, and marketing for which an individual authorization is not required

“Payment” means the activities undertaken by the physician to obtain reimbursement for the provision of health care. These activities referred to in this definition relate to the individual whom health care is provided and include, but are not limited to:

1. Determination of eligibility coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
2. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance, and related healthcare data processing;
3. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
4. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
5. Disclosure to consumer reporting agencies of any of the following information relating to reimbursement: name and address, date of birth, social security number, payment history, account number, and name and address of physician.

“Treatment” means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

“Use” means the sharing, employment, application, utilization, examination, or analysis of patient information within the physician’s practice that maintains such information.

HIPAA Privacy Statement - Addendum

This practice participates in a Health Information Exchange program where key clinical information about our patients' care is shared electronically, through a secure web portal, between this practice and other physicians/providers also providing care to our patients. Basic health information is shared with other treating physicians and providers. Sharing of basic health information in a Health Information Exchange is done so to have information available to better care for patients and the information is used for no other purposes.

LATER, if you decide that you no longer wish to participate, any information in The Health Information Exchange cannot be removed, but it will not be viewable because the patient identifying information will be inactivated. If you wish to exclude your basic health information from being included in this program, please inform the practice manager. You will be asked to sign a form documenting your wishes to "Opt-out".

The following information is defined by the State of Illinois as specially protected health information and should ***only*** be shared with the patient's written permission in the Health Information Exchange, eEHX. This specially protected information includes information concerning alcoholism treatment, drug abuse treatment, mental health services, developmental disabilities services, genetic testing and treatment, testing and treatment for HIV/AIDS/Sexually Transmitted Disease, treatment for child abuse/neglect, and treatment of sexual assault or abuse.

We have taken precautions to try and exclude this information from the Health Information Exchange, but there still is a small possibility that this information may be inadvertently sent to the HIE. **Therefore, if you have specially protected health information you should "Opt-out" of participating in the eEHX, or sign a consent that allows release of your specially protected health information.**

This practice also participates with the **Illinois State Immunization Registry and Public Health Disease Surveillance Registry**. Information will be sent electronically to the IL State registries about immunizations and state-required reportable diseases. This information is used by the State of IL to track Public Health needs. If you do not want your immunization information to be reported to the IL State Immunization Registry you may request to "Opt out" of this by signing an Opt-out form. This will not affect your care by your doctor.

Specialty Protected Health Information Authorization Form

Authorization to use and/or disclose protected health information in the Electronic Health Information Exchange.

___ YES. I authorize this practice to use and/or disclose a copy of my protected health information in the Electronic Health Information Exchange (eEHX) for the purpose of coordinating my medical care amongst my healthcare providers. I understand that including this information in eEHX enables any provider with authorized access to the eEHX to review my protected health information, including the following specially protected health information:

I acknowledge that I have been given sufficient information and have had the opportunity to have my questions answered about the Electronic Health Information Exchange (eEHX).

I understand that future withdrawal of permission to include this information in the Electronic Health Information Exchange (eEHX) will be effective except to the extent action has already been taken in reliance on this permission. When I withdraw permission my protected health information will be inactivated and the eEHX and will no longer be able to be accessed. This permission will expire if the eEHX program is discontinued.

I understand that my eligibility for treatment or any health care benefits cannot be conditioned on whether I sign this authorization form. However, to the extent I have indicated "YES" to the sharing of my protected health information, I understand that an electronic Health Information Exchange record will be available to other eEHX authorized users.

Authorized date(s) or date range

Printed Name of Patient/Representative

Signature of Patient/Representative

Date

AUTHORIZATION OF REPRESENTATIVE:

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis:

Relationship to Patient _____

[A signed copy of this permission will be provided to the patient/representative]

HEDGES CLINIC

Patient Self History (Please complete BOTH pages completely)

Patient Name: _____ Date: _____

Address: _____
CITY STATE ZIP

Birthdate: ____/____/____ Soc. Sec. No. ____-____-____

Email Add: _____@_____

MEDICAL CONDITIONS: Please check all past or present medical problems and/or symptoms.

- | | | |
|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Gout | <input type="checkbox"/> Prostate Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Head/Neck Injury | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rectal Polyps |
| <input type="checkbox"/> Bleeding Tendancies | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Recurrent Bronchitis |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hernia | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> High Blood Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Drug/Substance Abuse | <input type="checkbox"/> HIV | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Easily Bruised | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Knee/Thigh Injury | <input type="checkbox"/> Difficulty Urinating |
| <input type="checkbox"/> Fibroids | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Abnormal Vaginal Discharge |
| <input type="checkbox"/> Gastrointestinal Bleeding | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Abnormal Penile Discharge |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Visual Loss |
| | | <input type="checkbox"/> Other |

MEDICATIONS: Please check all of the following medications that you are currently taking.

- 1. I am taking medication but do not know the name or its purpose.
- 2. Allergy medicines
- 3. Asthma medicines
- 4. Blood thinners
- 5. Diet pills
- 6. Diuretics (water pills)
- 7. Heart medicines (nitroglycerin, digitalis, rhythm medicines)
- 8. High blood pressure medicines
- 9. Insulin
- 10. Oral diabetes medicines
- 11. Thyroid hormones
- 12. Tranquilizers
- 13. Other

Specify exact names, dosages, and how often you take the medications you indicated above:

ALLERGIES: List any medications or other substances that you are ALLERGIC to:

Social History: Do you smoke? If yes, how much and how often? _____

****PLEASE TURN OVER****

Do you drink alcohol? If yes, how often and how much? _____

Do you use illicit drugs? If yes, what kind and how often? _____

What is your occupation? _____

Is there any exposure to dust, fumes, smoke, noise? _____

Are you watching your diet or following any strict dietary guidelines? _____

Do you exercise regularly? _____

Do you take any non-prescription medications, health foods, vitamins? _____

PLEASE LIST ANY PAST SURGERIES:

_____ YEAR: _____

_____ YEAR: _____

_____ YEAR: _____

FAMILY HISTORY: (Immediate : father, mother, brothers, sisters, grandparents)

	Alive?	Age	Medical Problems or Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Other	_____	_____	_____
Other	_____	_____	_____

Health Screening/Immunizations:

Please specify if you had any of the following:
Date & Results

Pap Smear	_____
Mammogram	_____
Bone Density	_____
Chest x-ray	_____
Physical Examination	_____
Digital Rectal Examination	_____
Prostate Examination/PSA	_____
Stool Hemocults	_____
Flexible Sigmoidoscopy	_____
Colonoscopy	_____
Cholesterol	_____
Blood Sugar	_____
PPD/Tuberculosis Screening	_____
Influenza Vaccine	_____
Tetanus/TD	_____
Hepatitis B Vaccine	_____
Chicken Pox or Vaccine	_____
Body Mass Index	_____
Pneumovax	_____

Drs. Initials: _____ has reviewed this. UPDATED (yearly) _____