SAINT JOSEPH HEALTH SYSTEM
PHYSICIAN NETWORK

☐ FMC ☐ SJPN ☐ SMI

PATIENT INFORMATION

Last Name:_____ First Name:_____ MI:_____

Social Security: #_____ Date of Birth:_____ Sex: ☐ M ☐ F

Address:_____ City:_____ State:_____ Zip_____

1st Phone: _____ Leave Message: ☐ Yes / ☐ Yes with Family / ☐ No Message

☐ Home / ☐ Cell / ☐ Work

2nd Phone: _____ Leave Message: ☐ Yes / ☐ Yes with Family / ☐ No Message

☐ Home / ☐ Cell / ☐ Work

3rd Phone: _____ Leave Message: ☐ Yes / ☐ Yes with Family / ☐ No Message

☐ Home / ☐ Cell / ☐ Work

Preference for Appointment Reminders: ☐ Phone Message / ☐ Text Message

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown ☐ Declined

Language: ❑ English ❑ Spanish ❑ Other _____

Religion: _____

Ethnicity: (Heritage) ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined ❑ Unknown

Marital Status: ☐ M ☐ S ☐ Widowed ☐ Divorced ☐ Life Partner ☐ Other: _____

Spouse's Name: _____ Spouse's Work Phone: (___) _____

Patient E-Mail Address: _____ Patient Portal: ☐ Yes ☐ No

NEAREST RELATIVE OR EMERGENCY CONTACT PERSON (other than spouse)

Last Name: _____ First Name: _____ M:_____

Relationship: (if any) _____ Phone: (___) _____

GUARANTOR (RESPONSIBLE PARTY) INFORMATION

Last Name: _____ First Name: _____ MI:_____

Address:_____ City:_____ State:_____ Zip:_____

Relationship to Patient: _____ Sex: ☐ M ☐ F Employer's Name: _____

Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___) _____

Date of Birth: _____ Social Security: # _____

✶ PLEASE ALLOW US TO PHOTOCOPY/SCAN YOUR INSURANCE CARD(S) ✶

PLEASE FILL OUT IF CARD HOLDER INFORMATION DIFFERENT THAN GUARANTOR

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____ Copy of card? ☐ Yes ☐ No

Name of Insured: _____ Sex: ☐ M ☐ F Date of Birth: _____

Address:_____ City:_____ State:_____ Zip:_____

Insured's Social Security Number: _____

Is this an Employer's Plan? ☐ Yes ☐ No If so, Insured's Employer: _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____ Copy of card? ☐ Yes ☐ No

Name of Insured: _____ Sex: ☐ M ☐ F Date of Birth: _____

Address:_____ City:_____ State:_____ Zip_____

Insured's Social Security Number: _____

Is this an Employer's Plan? ☐ Yes ☐ No If so, Insured's Employer: _____

WORKMAN'S COMPENSATION: (Written authorization from employer is required)

Whom may we thank for your visit today? _____

PATIENT CONSENT

1. CONSENT TO MEDICAL CARE AND TREATMENT

I am being treated at _____ ("Physician Office"), and I consent to all medical and surgical care, examinations and tests determined by my Physician that are necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my Physician's recommendations as they may relate to my health that the Physician and this Office will not be responsible for any injuries or damages that are the result of my non-compliance. I understand that if an employee or any individual associated with Physician Office is exposed to my blood or body fluids, I will be tested for the hepatitis viruses and the Human Immunodeficiency Virus (HIV). I also understand that I will receive education related to this testing and that I will not be charged for testing and education related to the exposure.

2. CONSENT TO PHOTOGRAPH, VIDEOTAPE OR RECORD

_____ Initial

I authorize Physician Office to photograph, videotape or record me and agree that the negatives, slides, prints or tapes may be used for medical reasons (including training, education or research). I hereby release Physician Office, its employees, physicians and other authorized persons, from any responsibility or liability which might arise from the taking and authorized use of negatives, slides, prints or tapes.

3. CONSENT TO USE OF INFORMATION

Electronic Health Records. I understand that the Physician Office may collaborate with other health care providers to coordinate, manage and provide health care to me and I consent to the Physician Office's sharing my health information and records electronically for the purposes of treatment, payment or operations, including improving the overall quality of health care services provided to me (e.g., avoiding unnecessary or duplicate testing, etc.). I consent to the inclusion in the electronic health records of sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. The electronic health records (EHR) will be accessible by Trinity Health credentialed physicians/practitioners as well as other individuals approved to access the EHR for purposes related to treatment, payment, health care operations and/or other purposes permitted by federal and state laws, including the Health Insurance Portability and Accountability Act ("HIPAA"). The Physician Office has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of my medical information as required by HIPAA.

Use and Disclosure of Information. In addition to the above consent to use and share my health information with the Trinity Health EHR system, I agree that the Physician Office may use and disclose my health information for a range of purposes including: treatment, eligibility verification, and/or payment to private and public payers or their agents including insurance companies, managed care organizations, my employer (if I am injured at work), state and federal government programs, Workers' Compensation programs, obtaining pre-admission or continued length of stay certification, quality of care assessment and improvement activities, evaluating the performance of qualifications of physicians and health care workers, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory and accreditation requirements and public health and health oversight services.

Request for Information from Others. I consent to the Physician Office's request of my health information from other providers of care to me, receipt of and release of my health information, whether written, verbal, or electronic, for the uses described above as well as the Physician Office's participation in any health information exchange described in the Physician Office's Notice of Privacy Practices (NPP). Please refer to the NPP for additional, detailed information regarding the uses and disclosures of protected health information.

4. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ Initial

I acknowledge that I have received or been offered a copy of Physician Office's Notice of Privacy Practices which provides information on how the Physician Office may use or disclose PHI for purposes of treatment, payment, or health care operations.

5. ASSIGNMENT OF BENEFITS

I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to the Physician Office for services provided to me. I understand that benefits may be payable to me directly if I do not provide this authorization.

6. FINANCIAL RESPONSIBILITY

_____ Initial

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products provided or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid or other insurance or payers (e.g., services rendered by health care providers who do not participate with my insurance plan). Non-covered services also may include those services my physician determines to be medically necessary, but are later determined unnecessary by the payer.

7. PERSONAL VALUABLES. I understand that the Physician Office does not accept responsibility for any lost, stolen or damaged personal items while I am at the Physician Office.

Print *Patient Name:* _____ *Patient Date of Birth:* _____

_____

Patient Address / City / State / Zip Code

Sign _____ _____ _____

Patient or Legal Representative Signature *Date of Signature* *Relationship of Legal Representative to Patient*

MEDICARE AUTHORIZATION

I am giving SJRMC, Inc and its subsidiaries permission to ask for Medicare payments for my medical care. I understand that Medicare needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to Medicare and the companies that handle Medicare payment requests. I understand that the Center for Medicare and Medicaid Services (CMS) is the government Medicare agency.

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by SJRMC, Inc and its subsidiaries including physician services. I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits for related services.

*Signature*_____ *Date*_____

MEDIGAP AUTHORIZATION

I request that payment of authorized MediGap benefits be made either to me or on my behalf to the physicians of SJRMC, Inc and its subsidiaries, for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to_____ (Medigap insurer) any information needed to determine these benefits or the benefits payable for related services.

*Signature*_____ *Date*_____

NOTICE OF REFERRAL

At some point in your treatment your physician may choose to refer you to a specialist for testing, consultation, or treatment; this provider may or may not be in your health plan's network. To avoid unexpected charges for these services please note:

☐ 1. An out-of-network provider may be called upon to render health care items or services to you during the course of your treatment.

☐ 2. That out-of-network provider is not bound by the payment provisions that apply to Health care items or services rendered by an in-network provider under your health Plan.

☐ 3. You may contact your health plan before receiving health care items or services Rendered by an out-of network provider to obtain a list of in-network providers that may render the health care items or services, or to obtain additional assistance. Please refer to your insurance card for your health plan's telephone number.

*Patient Signature*_____ *Date*_____

☐ Yes ☐ No May we send text messages regarding appointment reminders? **Cell Phone**: _____

☐ Yes ☐ No May we leave messages, which may include but are not limited to, information about prescriptions, test results or appointments on your answering machine?

☐ Yes ☐ No May we leave messages, which may include but are not limited to, information about prescriptions, test results or appointments with members of your household?

Signature _____ *Date*_____

Guarantor received/informed of financial policy: ☐ Yes ☐ No

Guarantor received/informed of missed appointment policy: ☐ Yes ☐ No