Today's Date:_____

☐ Dr. ☐ Mr. ☐ Ms. ☐ Miss ☐ Mrs.

Patient name:_____ Date of birth:_____

Address:_____City: _____ State:_____ Zip code: _____

Home phone #: (_____)_____ Cell #: (_____)_____ Emergency #:(_____)_____

S. S. #: _____ E-Mail Address: _____

Patient Information

Sex: ☐ Male ☐ Female **Marital status:** ☐ Widowed ☐ Divorced ☐ Married ☐ Single

Race: ☐ Unknown ☐ Black, African American ☐ Asian ☐ White ☐ American Indian, Alaska Native ☐ Native Hawaiian, other Pacific Islander ☐ Declined

Ethnicity: ☐ Hispanic / Latino ☐ Non-hispanic / Non-Latino ☐ Declined ☐ Unknown

Primary language: _____

If child, child lives with: ☐ Mom ☐ Dad ☐ Guardian ☐ Foster parent*

*If foster parent, list agency: _____

Patient's employer: _____

Employer address: _____ Phone #:(_____)_____

Personal Contact Information

Emergency Contact

Name : _____Phone #:(_____)_____

Address:_____ Relationship:_____

If child, Mother's name:_____ S. S. #:_____

Address:_____ Date of birth: _____

Home telephone #: (_____)_____ Work telephone #: (_____)_____

Mother's employer: _____

If child, Father's name:_____ S. S. #:_____

Address:_____ Date of birth: _____

Home telephone #: (_____)_____ Work telephone #: (_____)_____

Billing name:_____ Billing address: _____

City: _____ State:_____ Zip Code: _____ Telephone #: (_____)_____ Guarantor S. S. #:_____

Guarantor / Billing Information

HEALTH INSURANCE

1ST INSURANCE NAME:

Claim address:_____ City: _____ State:_____ Zip code: _____

Telephone #: (_____)_____ Group #:_____ Policy #: _____

Subscriber's name and address: _____

Subscriber's date of birth: _____ S.S.#: _____Employer: _____

2ND INSURANCE NAME:

Claim address:_____ City: _____ State:_____ Zip code: _____

Telephone #: (_____)_____ Group #:_____ Policy #: _____

Subscriber's name and address: _____

Subscriber's date of birth: _____ S.S.#: _____Employer: _____

Please place patient label here.

Licking Memorial Health Professionals
Patient Registration

7500-0033

2/18/11, 3/18/11, 12/12/11, 3/21/12, 11/7/13, 12/2/15, 6/15/16

How did you hear about our practice?

Please check all that apply:

- ☐ Newspaper article or advertising
- ☐ Radio advertising
- ☐ Friend or relative. Please give name:_____
- ☐ Other: _____
- ☐ Physician referral service
- ☐ www.LMHealth.org website
- ☐ Newsletter
- ☐ Insurance directory

I authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV / AIDS confidential information, necessary to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities.

I assign all medical and / or surgical benefits including major medical benefits to which I am entitled to LICKING MEMORIAL HEALTH PROFESSIONALS. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original.

I understand, in order for Licking Memorial Health Professionals to survey my satisfaction with the care I receive, to service my account or to collect any amounts I may owe, Licking Memorial Health Professionals or any of their affiliates may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Licking Memorial Health Professionals may also contact me by sending emails, using any email address I provide. Methods of contact may include using prerecorded / artificial voice messages and / or use of an automatic dialing device, as applicable. I understand my consent to patient contact is not a condition of obtaining health care services and that I may revoke the consent for patient contact at any time by notifying the Central Billing Office at 220-564-4499.

I consent to the administration and performance of all customary examinations, tests and procedures relating to my condition. Other healthcare professionals may perform procedures based upon a physician's order or within their scope of practice.

Patient (or patient's legal representative) signature: **X**_____ Date:_____ Time:_____

Relationship to patient: ❑ Self ❑ Other: _____

Receipt of Licking Memorial Health Systems' Notice of Privacy Practices

My signature below indicates that I have been offered Licking Memorial Health Systems' Notice of Privacy Practices and I have ❑ Accepted ❑ Declined

Patient (or patient's legal representative) signature: **X**_____ Date:_____ Time:_____

Relationship to patient: ❑ Self ❑ Other: _____

Receipt of Licking Memorial Health Professionals' Patient Portal Terms and Conditions

My signature below indicates that I have been provided with Licking Memorial Health Professionals' Patient Portal Terms and Conditions.

Patient (or patient's legal representative) signature: **X**_____ Date:_____ Time:_____

Relationship to patient: ❑ Self ❑ Other: _____

Please place patient label here.

Licking Memorial Health Professionals
Patient Registration

7500-0033

2/18/11, 3/18/11, 12/12/11, 3/21/12, 11/7/13, 12/2/15, 6/15/16

Licking Memorial Health Systems
Authorization for Release of Medical Information

☐ ID verified ☐ Minor Staff initials: _____ Medical Record #: _____ (completed by LMHS)

Patient Information

Patient name: _____
Last First Middle initial Maiden (if applicable)
Address: _____ City:_____ State: _____ Zip: _____

Date of birth:_____ Social Security No: _____

Work phone: ( )_____ Home phone: ( )_____

Release To / From

I hereby Authorize Licking Memorial Health Systems to: (Please check only one box)

☐ Release my records to: ☐ Obtain my information from:

Name / facility: _____

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

Telephone: ( )_____ Fax: ( )_____

Information may be:

☐ Mailed ☐ Reviewed only ☐ Verbal exchange ☐ Fax: _____ ☐ Picked up by:_____

Copy my medical records to: (Please check one) ☐ Paper ☐ CD

Documentation can be released in an electronic format if stored in electronic media. Please check with Medical Records at 220-564-4132 to determine if your health information is available for electronic release.

Purpose of Disclosure

Records are to be released for the following purpose(s): (Please check all that apply)

- ☐ Continuity of care / medical treatment
- ☐ Personal use
- ☐ Changing doctor
- ☐ Other: _____
- ☐ Attorney / legal
- ☐ Insurance

Information Needed

Dates of Service(s) to be released: (specify dates - this line MUST BE completed)

_____

The information being requested is: (Please check all that apply)

- ☐ Discharge summary
- ☐ Consults
- ☐ Procedure reports
- ☐ Labs
- ☐ Cardiac studies
- ☐ Occupational Health records
- ☐ Discharge instructions
- ☐ Drug / alcohol information
- ☐ Home health records
- ☐ Other: _____
- ☐ History and physical
- ☐ Operative
- ☐ Emergency department report
- ☐ Imaging / radiology reports
- ☐ Physician orders
- ☐ Physician progress notes
- ☐ Psychological tests
- ☐ Radiology images / films
- ☐ Nursing notes

Please place patient label here

Licking Memorial Health Systems

C O N R O I N F

Authorization for Release of Medical Information

1768-0020
11/29/12, 12/12/12, 9/30/15, 10/31/16

Medical Record #: _____ (completed by LMHS)

Information Needed (Con't)

NOTE: If applicable, Psychotherapy notes require a separate authorization.

Mental Health, drug and alcohol, and communicable diseases including HIV (AIDS) or related illness may be contained in the parts of the records indicated above and will be released through this authorization unless otherwise indicated:

Do not release: ☐ HIV (AIDS) ☐ Mental Health ☐ Drug & Alcohol

Authorization

Authorization and Expiration:

This authorization will expire one year from the date it is signed unless it is otherwise revoked (withdrawn), or if specified on the following date, event or condition _____, not to exceed one year and covers only the dates of service specified above.

- I have read the above and authorize the staff at Licking Memorial Health Systems to disclose information from my medical record for the reasons and time specified to the party (parties) named in this document.
- I understand this authorization may be revoked (withdrawn) by me at any time, providing the information has not already been disclosed.
- I understand that once the information has been disclosed per my instruction, the information may no longer be protected by federal confidentiality laws.
- I understand that my treatment, payment, enrollment or eligibility benefits may not be conditioned on signing this authorization. Licking Memorial Health Systems is permitted to disclose my health information for treatment, payment, and operation purposes. Licking Memorial Health Systems is released and discharged of any liability and the undersigned will hold Licking Memorial Health Systems harmless for complying with this "Authorization for Release of Medical Information."
- **If applicable, a separate authorization will be required to release your psychotherapy notes.**
- You are entitled to a copy of this form. Please verbally request it, if you want a copy.
- I understand there may be charges for copying and release of this information.

Patient (or patient's legal representative) signature: X_____ Date:_____ Time:_____

Relationship to patient: ☐ Self ☐ Other: _____

Redisclosure

Prohibition Against Re-Disclosure: This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

Revocation

☐ I elect to revoke this authorization except to the extent that Licking Memorial Health Systems has relied on my previous authorization. This revocation will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.

Patient (or patient's legal representative) signature: X_____ Date:_____ Time:_____

Relationship to patient: ☐ Self ☐ Other: _____

Please place patient label here

Licking Memorial Health Systems

CONROINF

Authorization for Release of Medical Information