Registration #_____

REGISTRATION FOR PUTNAM PROMPT CARE CLINIC AND TRIAGE

- ***Please fill this form out and return to the receptionist as soon as possible.***

Legal Name _____ **Date of Birth**_____

Street Address_____

City_____ **State**_____ **Zip Code**_____

Best phone # _____ **Alt. Phone #** _____

Primary Care Physician_____ **Phone #**_____

Preferred Pharmacy_____ **City**_____

Reason for Visit_____

Do you currently Smoke? Yes / No Quit Date: _____

Is there a possibility you are pregnant? Yes / No Last cycle_____

If you are experiencing any of the following symptoms, please check ✓ the box and circle the symptom(s) below, then a Triage Nurse will ask to you:

- ❑ Do you ***currently*** have a fever **OVER** 101° or chills and sweats?
- ❑ Breathing problem: shortness of breath, wheezing, asthma attack
- ❑ Chest pain, rapid or irregular heart beat
- ❑ Severe pain of any kind: Location_____
- ❑ Injuries which are bleeding or may involve broken bones
- ❑ Fainting, dizziness
- ❑ Vomiting (please ask for a vomit bag from Receptionist)
- ❑ Uncontrollable cough **(MANDATORY mask)**
- ❑ UTI (urinary tract infection), urinary burning, frequent urination
- ❑ Vaginal Bleeding >1pad per hour.

For less serious injuries or illnesses, please check ✓ the box & circle the symptom(s) below for the reason for your visit:

- ❑ 1. Skin: rash, lump, bump, or insect bites
- ❑ 2. Headache today
- ❑ 3. Cold, cough, sore throat, earache, congestion, allergies, flu
- ❑ 4. Abdominal pain, nausea, vomiting, diarrhea
- ❑ 5. Genital discharge, sores, or other new problem
- ❑ 7. Rectal bleeding, soreness, constipation
- ❑ 8. Recent injury: when_____ nature of injury_____
- ❑ 9. Other

_____

MEDICAL HISTORY

DATE: **PUTNAM COUNTY HOSPITAL PHYSICIAN PRACTICES**

NAME: _____ DATE OF BIRTH: _____

CURRENT / RECENT SYMPTOMS *(What symptoms are you having?)*

MEDICAL HEALTH (*What Chronic health problems do you have?)*

MEDICATION ALLERGIES: *(Are you allergic to ANY medications?)* ☐ *yes* ☐ *no* *(if yes please list)*

NON-MEDICATION ALLERGIES: *(Are you allergic to any non-medications?* ☐ *yes* ☐ *no*

☐ Latex? ☐ Tape? ☐ Iodine?
☐ Contrast Dye? ☐ Shellfish? ☐ Other?

HEART HEALTH HISTORY:

☐ Congestive Heart Failure	☐ Heart Catheterization	☐ Heart Stents
☐ Coronary Artery Disease	☐ Heart Valve Disease	☐ Mitral Valve Prolapse
☐ Heart Attack	☐ Heart Murmur	☐ Peripheral Vascular Disease

MEDICATIONS: *(Are you currently taking ANY medications or vitamins?)* ☐ *yes* ☐ *no (If yes please list all medications)*

NAME OF MEDICATION	*DOSAGE*	*INSTRUCTIONS*

SURGERIES: (Please list all surgeries, include year if known)

PATIENT INFORMATION FORM
PUTNAM PHYSICIAN PRACTICES

PATIENT INFORMATION DATE:_____

Last Name: _____ First: _____ M.I. _____

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

Social Security #: _____ Date of Birth: _____ Sex: _____ Marital status: _____

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

Employer: _____ Full-time / Part-time OR Retired OR Disabled

Student: Full-time / Part-time OR Not a student____

Primary Care Provider: _____ Referring Provider: _____

Would you like web access to your medical records? Yes ___No____If Yes, provide your Email:_____

Please indicate the preferred method for us to contact you. · by web portal · by phone · by mail

Ok to leave detailed message on answering machine or voicemail? Yes ____ No ____

Race:		**Language:**	**Ethnicity:**
_White	**_Asian**	**_English**	**_Hispanic/Latino**
_Black/African American	**_American Indian/Alaska Native**	**_Spanish**	**_Not**
_Native Hawaiian/Pacific Islander	**_Refuse To Report**	**_Other_____**	**_Refuse to Report**

PRIMARY EMERGENCY CONTACT

NAME:_____

Date of Birth:_____

Phone #_____

Relationship:_____

Please indicate the information covered by this authorization:

__ Appointment status/scheduling

__ Medical testing results and diagnosis

__ Financial Records

__ ALL OF THE ABOVE AND NOT LIMITED TO

SECONDARY EMERGENCY CONTACT

NAME:_____

Date of Birth:_____

Phone #_____

Relationship:_____

Please indicate the information covered by this authorization:

__ Appointment status/scheduling

__ Medical testing results and diagnosis

__ Financial Records

__ ALL OF THE ABOVE AND NOT LIMITED TO

Is this patient covered by insurance? Yes ___ No ___

PRIMARY INSURANCE: Name of Insurance Company: _____ ID #_____

Policy Holder's full name:_____ SS#:_____ Date of Birth:_____

Relationship to patient:_____

SECONDARY INSURANCE: Name of Insurance Company: _____ ID #_____

Policy Holder's full name:_____ SS#:_____ Date of Birth:_____

Relationship to patient:_____

RESPONSIBLE PARTY INFORMATION: Self: _____ Relationship to Patient: _____ Patient lives with you? Yes No

Full Name: _____Phone #: _____ Date of Birth:_____

Mailing Address: _____ City: _____ State: ___ Zip: _____

Do you have an Advanced Directive? Yes ___ No ___

I was offered a copy of the "Notice of Privacy Practices" Yes ___ No ___

SIGNATURE:_____Relationship to Patient: _____

(My signature confirms that all the information I have reported is correct)

AUTHORIZATION OF CARE / ASSIGNMENT OF BENEFITS

ALL TEST RESULTS WILL BE PROVIDED TO PATIENT AT THE TIME OF VISIT OTHERWISE THE PATIENT WILL BE INSTRUCTED TO FOLLOW UP WITH THEIR PRIMARY CARE PHYSICIAN.

If patient is under the age of 18, we must have a parent/legal guardian authorization before patient is seen.

CONSENT TO TREAT:

(The term healthcare provider(s) in this document means Putnam Prompt Care, its agents, employees, members of the medical staff and their agents and employees, and other healthcare practitioners who provide care to patients.)

Permission is hereby granted to all healthcare providers involved in my care to administer such examination, treatment, testing and procedures as are deemed necessary in the course of my care.

FINANCIAL RESPONSIBILITY/HMO MEMBERS

I authorize any HMO insurance plan in which I am enrolled to pay benefits directly to my HMO healthcare provider. I agree to pay all relevant co-payments for services covered by my HMO plan. Payment for services not covered by my HMO benefits will be my responsibility. If co-payments and payment for non-covered services are not paid appropriately, collection of the amount due shall be as described under Financial Responsibility/Assignment of Benefits section. Co-payments are due at the time of service.

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

For those healthcare providers who accept assignment, I hereby authorize any insurance carrier with whom I have a policy to pay directly to those healthcare providers who have rendered services to me, any benefits of any policies of insurance and who accept assignment.

I agree to pay all charges not paid in full by assigned insurance. If amounts due to the healthcare provider are not paid after reasonable notice, the account shall be deemed delinquent. In the event that I default on payment of my account, I agree to be responsible for collections fees and interest due on amounts in default, including court costs and reasonable attorney fees. If the debt is assigned to a third party for collection, I agree to be responsible for collections fees.

I understand I may be contacted at any telephone number associated with my account including wireless telephone numbers. Methods of contact may include using pre-recorded/artificial voice messages and/or use of any automatic dialing device, as applicable.

IF AT ANY TIME SERVICES ARE RELATED TO WORKMEN'S COMPENSATION OR AUTO ACCIDENT, I UNDERSTAND I MUST INDICATE PUTNAM PROMPT CARE BEFORE THE INITIAL VISIT. UPON FAILURE TO NOTIFY OF SUCH, I AGREE TO BE FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED.

CLAIM PAYMENT AUTHORIZATION AND INFORMATION RELEASE

I understand my signature indicates payment by my insurance and/or Medicare carrier be made to my healthcare provider of any services furnished me by that provider. I authorize my healthcare provider to release medical information to my insurance and/or Medicare carrier needed to determine those benefits payable for such service

I understand I am responsible for deductibles, coinsurance and non-covered services as determined by my insurance and/or Medicare carrier.

A photocopy of these authorization assignments shall be valid as the original
A copy of this document may be given upon request

_____ _____

Patient signature | Legal Guardian Signature (If patient is under 18 yrs old)

_____ _____

Patient's Name (Please Print) | Legal Guardian Name (Please Print)

Date signed_____

Putnam County Hospital

NOTICE OF PRIVACY PRACTICES
PHYSICIAN PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

USES AND DISCLOSURES

TREATMENT: Your health information may be used by staff member or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

PAYMENT: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

HEALTHCARE OPERATIONS: Your health information may be used as necessary to support the day-to-day activities and management of Putnam County Hospital Physician Practices. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

LAW ENFORCEMENT: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigation, and to comply with government-mandated reporting.

PUBLIC HEALTH REPORTING: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

ADDITIONAL USE OF INFORMATION

Appointment reminders: Your health information may be used by our staff to send you appointment reminder.

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of you medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. These include:

*the right to request restrictions on the use and disclosure of your protected health information
*the right to receive confidential communications concerning your medical condition and treatment.
*the right to inspect and copy your protected health information
*the right to amend or submit corrections to your protected health information
*the right to receive an accounting of how and to whom your protected health information has been disclosed
*the right to receive a printed copy of this notice

Putnam County Hospital Physician Practices DUTIES:
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.
We are also required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES
As permitted by law, we reserve the right to amend or modify our privacy our privacy policies and practices. These changes in our policies and practice may be required by change in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

REQUEST TO INSPECT PROTECTED HEALTH INFORMATION
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by using the contact information listed at the end of this notice. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request. If you request copies, we will charge you a $15.00 retrieval fee for the first 25 pages and $.25 for each page thereafter.

COMPLAINTS
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: Privacy Officer

Putnam County Hospital Physician Practices
1542 S Bloomington
Greencastle, IN 46135
765-658-2717

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. Under no circumstances will you be penalized or suffer retaliation for filing a complaint.