RMH | RANSOM MEMORIAL HEALTH

PATIENT REGISTRATION FORM

Physician Practices of Ransom Memorial Health

Patient Name: _____
(First Name) (Middle Name/Initial) (Last Name)

Address: _____

City, State, Zip: _____ Sex: ❑ M ❑ F Marital status: ❑S ❑M ❑D ❑W

Social Sec #: _____ **Birth date:** _____

Home phone: (_____) _____ Cell phone: (_____) _____ Carrier:_____

Race: _____ Ethnicity: _____ Preferred Language: ❑ English ❑ Spanish

Employer: _____ Occupation: _____

Employer's Address: _____ Work Phone: (_____) _____

Primary Care Physician: _____ Referring Physician: _____

If not referred by another physician, how did you learn of our office/clinic?

❑ Community word of mouth ❑ Referral from Employer ❑ Community Event
❑ Referral from friend or family ❑ Print Advertisement ❑ Website/On-line directory
❑ Referral from non-medical facility/business ❑ Other_____

***Please provide e-mail address:** _____

***May we text or email you appointment reminders? ❑ Yes ❑ No**

EMERGENCY CONTACT: _____ Relationship:_____

Home Phone: (_____) _____ Cell phone: (_____) _____

To whom should your statement be sent?
Please note that unless you are a minor or have a legal guardian/POA you are responsible for payment of your charges regardless of where the statement is sent.

❑ **Self** ❑ **Spouse** ❑ **Parent/ Guardian** ❑ **Worker's Comp** ❑ **Other:** _____

RESPONSIBLE PARTY OR BILL TO INFORMATION:

Full Name: _____ **Relationship to patient**: _____

Birth Date: _____ Social Sec. #: _____

Address: _____ City, State, Zip: _____

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

Employer: _____

PERMISSION TO DISCLOSE TO THOSE INVOLVED IN MY CARE

I hereby allow RMH Physician Practices to discuss the following health information to the persons listed below:

- Appointment times and date
- Tests that have been received
- Test results
- Financial/ Business office information- other health information

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ **Date:** _____

Patient Name: _____

INSURANCE INFORMATION

Please have your photo ID and insurance card(s) handy so that we may scan the information into your record.

PRIMARY INSURANCE: _____ Work Comp ❑ Auto ❑ Other ❑

Address_____ City/State/Zip_____

Phone # (usually found on back of ins card): (_____) _____

Insured's Name: _____ Relationship to Patient: _____

ID #: _____ **Insured's Date of Birth**: _____

Group #/Name: _____

SECONDARY INSURANCE: _____ Work Comp ❑ Auto ❑ Other ❑

Address_____ City/State/Zip_____

Phone # (usually found on back of ins card): (_____) _____

Insured's Name: _____ Relationship to Patient: _____

ID #: _____ **Insured's Date of Birth**: _____

Group #/Name: _____

CONSENT TO TREATMENT /ASSIGNMENT OF INSURANCE BENEFITS & ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY:

By signing & dating below I am acknowledging my understanding of and consent to the following:

- I hereby give permission for (medical / surgical) treatment.
- I hereby authorize the release of information pertinent to the processing of my benefits as required by my insurance company(ies). I also authorize payment of benefits directly to RMH Physician Practices.
- I have been offered and/or given a copy of the Financial Policy for RMH Physician Practices and allowed to ask any questions I may have. I understand that I am financially responsible for all charges incurred during the course of my care and I agree to comply with the aforementioned Financial Policy in its entirety.

Signature: _____ **Date:** _____

MEDICARE PATIENTS ONLY/ ONE TIME AUTHORIZATION:

Name of Beneficiary: _____

Medicare ID #: _____

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Ransom Memorial Health Physician Practices for any services furnished to me by their contracting providers. I authorize Ransom Memorial Health Physician Practices to release to the Centers for Medicare & Medicaid (CMS) and its agents, upon their request, any information needed to determine benefits payable for related services.

Signature: _____ **Date:** _____

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Notice of Privacy Practices
Summary & Acknowledgement

Maintaining privacy of your health information is very important to us. We have our *Notice of Privacy Practices* available by request. If needed, we will provide you with a copy. ***The following is a brief summary of the Privacy Practice Notice only, the actual Policy document should have been provided separately. If you did not receive a copy to review, please ask the receptionist for one.*** We encourage you to read the entire Policy and ask any questions you may have regarding its contents prior to signing this Acknowledgement.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

This section describes the different ways we may use or disclose your health information without first obtaining a specific authorization from you. Law specifically permits these types of uses and disclosures because it is assumed you would want us to use or disclose your information for these purposes, or because such use or disclosure is recognized as critical to the functioning of our health care system.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

This section describes the following rights you have with respect to your health information and tells you how you may exercise these rights.

- Right to inspect and copy
- Right to request amendment
- Right to an accounting of disclosures
- Right to request restrictions on certain uses and disclosures
- Right to request alternative means of communication
- Right to receive a paper copy of our Notice of Privacy Practices

HOW TO FILE COMPLAINTS CONCERNING OUR PRIVACY PRACTICES

This section tells you what you can do if you believe any of your rights have been violated. You will not be penalized for filing a complaint.

We ask you acknowledge your receipt of this Notice by signing below. If you wish to receive a copy you may request it at any time. The most current copy of our Notice will be posted in our office. If there are material changes to this Notice at a later date you will be provided a copy of the revised Notice and asked to sign another acknowledgement.

I acknowledge that I have had the opportunity to look over and request a copy of the Privacy Practices.

_____ _____

Signature of Patient/Patient Representative **Date**

_____

Relationship to Patient

RMH Physician Practices
1301 S. Main Street
Ottawa, KS. 66067