FAC

CoxHealth
Springfield, MO
Regional Services

Patient Sticker

PATIENT REGISTRATION FORM

Patient's Legal Name:_____ SSN#: _____ Date: _____

Address: _____ City/State/Zip: _____

Birth Date : ____/____/_____ **Sex:** ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino **Language:** ☐ English ☐ Spanish ☐ Other: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander

Please complete all fields and check the phone number you would prefer messages to be left regarding your health care.

☐ Home Phone: _____ ☐ Cell Phone: _____ ☐ **Email:** _____

Name of **Patient's Employer**: _____ Work Phone: _____

Patient's Employer Address: _____ City/State/Zip: _____

Spouse Name: _____ **Spouse** Work/Cell Phone: _____

Emergency Contact and Relationship: _____ Phone: _____

INSURANCE INFORMATION

Is this visit related to an accident? ☐ Yes ☐ No If yes, please specify if AUTO or Other: _____

Is this visit related to a work related accident? ☐ Yes ☐ No If yes, please provide Workman's Comp Ins.

♦ **PRIMARY INS:** _____ **POLICY HOLDER NAME:** _____

Policy Holder's Employer: _____ Policy Holder SSN#: _____

Group #: _____ Policy/ID #: _____ Policy Holder DOB: _____

Patient's Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other (explain) _____

♦ **SECONDARY INS:** _____ **POLICY HOLDER NAME:** _____

Policy Holder's Employer: _____ Policy Holder SSN#: _____

Group #: _____ Policy/ID #: _____ Policy Holder DOB: _____

Patient's Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other (explain) _____

PARENT OR GUARDIAN INFORMATION

Complete for Patients who are Minors or Patients with Guardians ONLY

♦ **RELATIONSHIP:** ☐ **Father** ☐ **Mother** ☐ **Guardian**

Name: (First, MI, Last) _____ SSN#: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____ Home Phone: _____

Employer: _____ Work Phone: _____ Cell Phone: _____

♦ **RELATIONSHIP:** ☐ **Father** ☐ **Mother** ☐ **Guardian**

Name: (First, MI, Last) _____ SSN#: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____ Home Phone: _____

Employer: _____ Work Phone: _____ Cell Phone: _____

NEW PATIENTS ONLY - How did you hear about us?

☐ Physician (Recommendation/Referral) (AP) ☐ Website - CoxHealth (WS) ☐ Wal-mart Clinic (WC) ☐ Social Media (SM) ☐ Email (EM)
☐ Emergency Room/Urgent Care (UC) ☐ Heathsense Magazine (HM) ☐ Mailer/Postcard (MP) ☐ Newspaper (PA) ☐ Other (OT)
☐ Health Plan Directory/Insurance Company (HP) ☐ Billboard/Sign (BS) ☐ Online Search (OS) ☐ Radio (RT)
☐ Friend/Relative/Neighbor (FR) ☐ Cox INFO Line (IL) ☐ Phone Book (PB) ☐ TV (TV)

OVER – Please Read and Sign

"A copy of this authorization shall be as effective and valid as the original."

AUTHOR

CoxHealth
Springfield, MO
Health Information Management

Patient Sticker

AUTHORIZATION, FINANCIAL OBLIGATION and CONSENT

Authorization to Release Information. I authorize the disclosure of any or all information in my medical or accounting record, including information regarding the diagnosis or treatment of HIV, AIDS, mental illness, or substance abuse, to any person, corporation or agency responsible for determining the necessity, appropriateness, payment or other matters related to CoxHealth treatment or services. This includes, but is not limited to, insurance carriers and companies, managed care plans, health maintenance organizations, preferred provider organizations, workers' compensation carriers, welfare agencies, Medicaid, or Medicare and its intermediaries and carriers, or my employer, which may be necessary to process any claim related to this hospitalization or outpatient service. I further agree that if my injury is work-related, I authorize the disclosure of my medical record related to my work-related injury to my employer or employer's representative.

Assignment of Benefits. I assign to CoxHealth or the Covered Entities listed below the benefits due to me for CoxHealth services from my insurance carrier or company, managed care plan, health maintenance organization, Medicaid, or Medicare and its intermediaries and carriers.

Medicare Beneficiaries. I authorize CoxHealth to obtain information from the Social Security Administration regarding my entitlement to benefits and my health insurance claim numbers.

Financial Obligation. I agree that I am financially responsible for payment of all amounts due for services provided by CoxHealth and the physicians. I further understand that I am responsible to pay for such services regardless of whether I have insurance coverage or whether other parties may also be responsible for paying for my care. I will not be responsible to pay for such services rendered if my financial obligation is waived by contractual agreements between CoxHealth and my insurer, or if prohibited by applicable state or federal laws or regulations. I agree to pay interest at the legal rate as defined by §408.020 RSMo. if the amount for which I am responsible is not paid within ten (10) days of receipt of the bill. In the event of collection, I authorize CoxHealth or any of its collection agencies attempting to collect any unpaid balance on my account to contact me at any number I have provided as contact information using any manner they choose, including using an auto-dialing device. I agree that the cost of collection, including reasonable attorney's fees and court costs, will be included as part of my financial obligation to CoxHealth and the entities listed below. This agreement shall be governed by Missouri law, and I hereby waive venue and agree that venue shall be appropriate in Greene County, Missouri.

Covered Entities. This Authorization, Financial Obligation and Consent Form applies to Lester E. Cox Medical Centers ("CoxHealth") facilities, departments and clinics including SNI Imaging, Ferrell-Duncan Clinic as well as its affiliated entities including Oxford Healthcare; Cox HPS of the Ozarks, Inc.; Cox-Monett Hospital, Inc.; Ozark Neuro Rehab; Cancer Research for the Ozarks, (all entities collectively referred to as "Cox Health") and the following hospital-based independent provider groups as applicable: Ozark Anesthesia Associates, Inc., Litton & Giddings Radiological Associates, Inc.; Pathology Services of Springfield, Inc.; Emergency Physician of Springfield, Inc.; EJW Anesthesia, Inc.; and Visionary Imaging, Inc. (all entities and hospital based groups collectively referred to as "Covered Entities")

I UNDERSTAND I MAY RECEIVE SEPARATE BILLS FROM EACH ENTITY NAMED IN THIS PARAGRAPH.

Consent for Treatment. I agree, request and authorize the employees or, contractors of CoxHealth and its Covered Entities to provide healthcare services to me and further consent to any examination, tests or procedures that may be advisable or necessary for routine diagnostic purposes or to diagnose or treat my medical condition. I realize that among those who attend to patients at CoxHealth and its Covered Entities are medical, nursing and other healthcare personnel in training who may be present and participating in my care as part of their education. I authorize the taking of photographs or other images of me or parts of my body for use in medical evaluation and education. I am aware that the practice of medicine is not an exact science and understand that no promise, guarantee or warranty has been made regarding the results of the examination or treatment I receive. I understand that the employees and contractors of CoxHealth and the Covered Entities do not routinely test patients for hepatitis or human immunodeficiency virus (HIV). I agree to have my blood tested for hepatitis or HIV infection, if my physician determines that it is necessary or if an employee, provider, volunteer or contractor of CoxHealth or its Covered Entities is exposed to my blood or bodily fluids. If my blood indicates infection, my physician will be notified as well as any other individual, entity or agency required by law.

Release of Responsibility for Valuables. I understand that CoxHealth strongly recommends that all personal belongings and valuables be sent home or placed in CoxHealth's security for safekeeping until I am discharged. I understand that CoxHealth will not be liable for loss or damage to any personal property I may choose to keep with me and will not replace any personal items if they are lost or stolen.

The CoxHealth Notice of Privacy Practices and The Notice of Patient Rights regarding my healthcare visit has been provided to me. The Notice of Privacy Practices was revised October 2013 and is available upon request.

I certify that I have read all parts of this Authorization, Financial Obligation and Consent Form, accept all its terms and conditions, that all representations made by me are true, and that a copy of this form is effective and valid as the original. I further acknowledge that I have been informed of the Patient Bill of Rights and Responsibilities. This Authorization, Financial Obligation and Consent Form expires (unless expressly revoked at an earlier date) one (1) year after the date indicated below.

Patient parent if minor child, or guardian, (If Patient unable to sign, Representative name and Relationship)	Date	__ Primary insured if different from patient __ Secondary insured if different from patient __ Guarantor if different from patient	Date
		Witness	Date

CONSNT

CoxHealth
All Entities and Locations
www.coxhealth.com

Name: _____
Age: _____ DOB: _____
Acct or SSN: _____
(or Patient Sticker Here)

PERMISSION TO SHARE

Permission to Verbally Share Information with Those Involved in Your Care

(Signed original will be scanned into Cerner and a copy will be provided to the patient.)

Many patients want their healthcare provider to verbally share medical and/or billing information with specific family members, friends, or others participating in their care. The purpose of this annual authorization is to communicate with your healthcare provider regarding who may have access to this information.

Patient Identification:

Legal Name: _____ Date of Birth: ____/____/_____

Full Address: _____

I authorize the release of financial and protected health information (PHI) from the following:

__ The entire CoxHealth systemand its Affiliated Covered Entities.

__ Do not disclose information from the following entity(s): _____

- In the case of an emergency situation CoxHealth may determine that a limited disclosure may be in my best interests and I realize CoxHealth may share limited PHI or other information with those who may be involved in my care.
- I realize this form does NOT authorize the person(s) below to make healthcare decisions for me or to view or receive copies of my medical records.

			Type of Information			
Name:	Phone Number:	Relationship to Patient:	All	Scheduling / Appointment	Medical	Insurance / Billing

This covers the following time frames. If NOT marked, all past, present and future encounters are the default.

__ All past, present, and future encounters/visits -OR- Other: _____

By signing this authorization form, I understand that:

- PHI may include records relating to psychiatric or psychological care; communicable diseases; HIV/AIDS diagnosis or treatment; alcohol or drug abuse treatment; sexually transmitted diseases; and other sensitive information.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Time Limit and Right to Revoke:
Except to the extent that action has already been taken in reliance on this authorization, I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to my physician's clinic if I am a clinic patient or registration/nursing staff if I am a hospital patient. Unless otherwise revoked, this authorization will expire one (1) year from the date signed.

Signature of Patient / Legal Representative:

_____ Date: _____ Time: _____

Relationship to Patient: _____