CHI St. Luke's Health

REGISTRATION FORM - (PLEASE PRINT)

Date:	**PCP's** last name:	First:	Middle:	PCP Ph:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) ❑Single ❑ Mar ❑ Div ❑Sep ❑ Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Race:	Ethnicity:	Religion Preference:

Email:	Language:	Interpreter Needed: ❑ Yes ❑ No

Street address: Apt #	Social Security:	Home ph: ( ) Cell ph: ( ) Work ph: ( ) To which # do you wish to receive appointment reminders?

P.O. Box:	City:	State:	ZIP Code:

Employment Status: ❑ Full Time ❑ Part Time ❑Unemployed ❑ Student ❑ Other:	Employer:	Employer ph: ( )

Pharmacy's Name	Pharmacy's Ph: ( )

How did you hear about us:

INSURANCE INFORMATION

(Please give your insurance card & ID to the receptionist)

Person responsible for bill:	Birth date: / /	Address (if different from patient):	Home ph: ( ) Cell ph: ( )

Occupation:	Employer:	Employer address:	Employer ph: ( )

PRIMARY INSURANCE

Name of primary insurance:_____

Subscriber's name:_____

Subscriber's S.S.:_____

Birth date:_____

Group:_____

Policy#:_____

Co-payment: $ _____

Patient's relationship to subscriber:
❑ Self ❑ Child ❑ Spouse ❑ Other

SECONDARY INSURANCE

Name of secondary insurance :_____

Subscriber's name:_____

Subscriber's S.S.:_____

Birth date:_____

Group:_____

Policy #:_____

Patient's relationship to subscriber:
❑ Self ❑ Child ❑ Spouse ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home ph: ( ) Work ph: ( ) Cell ph: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my insurance company to release any information required to process my claims. I acknowledge receipt for the notice of privacy policies and practices of this clinic.

_____ _____

Patient/Guardian signature *Date*

CHI St. Luke's Health
Imagine better health.℠

Patient Registration Form
AGAPE Physicians

Patient History Form

Patient Name: _____ **Date:** _____

Medications
Please list all medications you are currently taking, prescription and nonprescription, and their dosage:

Medications	Dose
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES:
ARE YOU ALLERGIC TO ANY MEDICATIONS?
____ YES ____ NO
If yes, please list the name of the Medications and the type of reaction:

_____
_____
_____
_____

ARE YOU ALLERGIC TO ANY FOODS?
___ YES ___NO
If yes, please list: _____
_____

Past Medical History
Please indicate if you have ever experienced any of the following conditions.

- ☐ Alcohol dependence
- ☐ Allergies (pollen, food)
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood clots
- ☐ Broken bones
- ☐ Cancer
  Type: _____
- ☐ Congestive heart failure
- ☐ COPD/Emphysema
- ☐ Depression
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Esophageal reflux
- ☐ Gallbladder stones
- ☐ Gout
- ☐ Heart Attack
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Hypothyroidism
- ☐ Insomnia
- ☐ Irritable bowel syndrome
- ☐ Hepatitis
- ☐ Kidney Stones
- ☐ Fatty Liver Disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Seizures/epilepsy
- ☐ Sleep apnea
- ☐ Stomach ulcer
- ☐ Stroke (CVA)
- ☐ Other Chronic Diseases:

_____
_____
_____

Patient Registration Form

AGAPE Physicians

Surgical History

Please check all that apply and the date of the procedure:

	Date		Date
□ Angioplasty	____/____/____	□ Gastric Bypass	____/____/____
□ Angioplasty w/stent	____/____/____	□ Hernia repair	____/____/____
□ Appendectomy	____/____/____	□ Hip replacement	____/____/____
□ Back surgery	____/____/____	□ Knee replacement	____/____/____
□ Carpal Tunnel Release	____/____/____	□ Liver Biopsy	____/____/____
□ Cataract extraction	____/____/____	□ Pacemaker	____/____/____
□ Colon surgery	____/____/____	□ Thyroidectomy	____/____/____
□ Coronary Artery Bypass Graft	____/____/____	□ Tonsillectomy	____/____/____
□ Gallbladder (Cholecystectomy)	____/____/____	□ Other: _____	____/____/____

Female Surgical History

Please check all that apply:

	Date
□ Augmentation Mammoplasty	____/____/____
□ Bilateral tubal ligation	____/____/____
□ Breast biopsy	____/____/____
□ Cesarean section	____/____/____
□ D and C (dilation and curettage)	____/____/____
□ Mastectomy	____/____/____
□ Reduction Mammoplasty	____/____/____
□ TAH/BSO Total Abdominal Hysterectomy)	____/____/____
□ Vaginal Hysterectomy	____/____/____
□ Other: _____	____/____/____

Male Surgical History

Please check all that apply:

	Date
□ Prostate biopsy	____/____/____
□ TURP (Trans-Urethral Resection of the Prostate)	____/____/____
□ Vasectomy	____/____/____
□ Other: _____	____/____/____

Family History

Please check if any family member has had any of the following conditions and indicate the name of the affected member, the age of onset and/or if it was the cause of death. □ **Adopted**

	Mother	Father	Sibling(s)	Children
□ Alcoholism				
□ Alzheimer's				
□ Heart disease				
□ Cancer: Type: _____				
□ Depression				
□ Diabetes				
□ High Cholesterol				
□ Hypertension				
□ Kidney Disease				
□ Osteoporosis				
□ Stroke				
□ Seizures				

Patient Registration Form

AGAPE Physicians

Social History

Do you currently use tobacco? ☐ Yes ☐ No If yes, how many packs per day? _____
What year did you start smoking?_____
Have you previously smoked? ☐ Yes ☐ No If yes, how many packs per day? _____
What year did you start smoking?_____ What year did you stop smoking?_____
Other Tobacco units per day (cans, cigars, etc.)? ☐ Yes ☐ No

Units per day? _____ Years used? _____ Year quit? _____

Do you drink caffeine? ☐ Yes ☐ No Type?_____ Amount Daily? _____
Do you drink alcohol? ☐ Yes ☐ No ☐ daily ☐ weekly ☐ monthly Amount: _____
What do you typically drink?_____

Immunizations

Do you have copies of your immunization records? ☐ Yes ☐ No

Preferred Pharmacy Information

1. **Local Pharmacy:_____ Phone Number: _____**

   Address:_____

2. **Mail In Pharmacy:_____ Phone Number: _____**

   Address:_____

HEALTH MAINTENANCE (if applicable)

Last Mammogram: _____ Results: _____

Last Well Woman/Well Male Exam: _____

Colonoscopy: _____ Results: _____

Last PAP Smear : _____ Results: _____

Flu Vaccine Date: _____

Pneumonia Vaccine Date: _____

Tetanus Vaccine Date:_____

ADDITIONAL INFORMATION

_____

_____

Authorization to Release Protected Health Information to Delegate

Patient Name (print):_____ **DOB:** _____

By signing this form, I authorize CHI St. Luke's Medical Group to disclose protected health information such as office consultations, labs, radiology and other test results to the person or people listed below. I understand that it is my responsibility to update this release form if necessary and/or remove delegates.

CHI St. Luke's Medical Group May Release my protected health information to the following people:

Name:_____Relationship to Patient: _____

Name:_____Relationship to Patient: _____

Name:_____Relationship to Patient: _____

Preferred Contact Method

CHI St. Luke's Medical Group will often contact patients for appointment reminders and testing results. Please indicate the method in which our office may contact you and or leave messages on authorized phone numbers.

_____Initial Primary Contact Number _____ cell/home/work/other

_____Initial Secondary Contact Number _____ cell/home/work/other

_____Initial I do not wish to be contacted in any other manner than a direct conversation, no messages may be left.

Patient /Guardian Signature_____

Authorization and Assignment Acknowledgement Form

My signature certifies I have read and understand the content of the Auth. & Assignment Acknowledgement document.

Patient / Guardian Signature_____

HIPAA **Acknowledgement of Review of Notice of Privacy Practices**

I have reviewed this office Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ **Date:** _____

Patient / Guardian Signature

_____ _____

Relationship (if not the patient) **SLMG Witness**

Patient Name: _____ **Patient DOB:** _____/_____/_____ **Date:** _____/_____/_____

Peter Bigler, MD Erika Brito-Goodson, MD Jerissa Belsha, MD Brittany Besong, PA-C Christi Dodd, PA-C Demetria Borges, PA-C

Wellness Update

Do you consistently experience any of these symptoms?	**Yes** (how often/how long do symptoms last?)	**No**
Runny Nose		
Itchy Nose		
Stuffy Nose		
Itchy Eyes		
Watery Eyes		
Frequent Sneezing		
Itchy Mouth/Lips/Throat		
Post Nasal Drip (drainage down the back of the throat, clearing throat)		

Do you currently take over-the-counter (OTC) for the management of your allergy symptoms? □**Yes** □**No**

If yes, name of medication and last date taken: _____

Please indicate below symptoms/conditions you've experienced during the last 1-2 years

□ Sinus related issues (sinus pressure/pain, headaches, sinusitis)

□ Eczema

□ Chronic colds (lasting longer than 2 months)

□ Migraine Headaches

□ Feeling of fatigue, irritability, and restlessness

□ Consistent or Re-Occurring cough

□ Asthma

Patient/Guardian Signature: _____ **Date:** ____/____/____

Patient Phone: _____

FOR PROVIDER USE ONLY:

Order Allergy Test: □ **Yes** □ **No**

Date of last ENT exam: _____/_____/_____

Provider Signature: _____ **Date:** _____/_____/_____

CHI St. Luke's Health

Authorization and Assignments

Thank you for choosing CHI St. Luke's Health Medical Group. We realize you have a choice in selecting healthcare and we are honored you have chosen us. Our staff is committed to providing our patients with the highest quality of care possible. In doing so, we would like to provide you with information regarding our office policies. Please feel free to contact or office anytime Monday – Friday during routine business hours if you have questions, concerns, or suggestions.

Office Policy

Our providers participate with many health plans and as a courtesy to our patients, we file claims with these companies. It is ultimately your responsibility for the full and timely payment of your account.

Check In

Please be prepared to submit the following documents when checking in for each visit. These documents will be scanned and saved as part of your patient record.

- Current Insurance Card
- Current Photo Identification
- Update to contact information such as home address, phone numbers, contact information, email address, employer information, etc.

Verification of Benefits

We will attempt to verify coverage and benefits prior to your visit. If we are unable to obtain a verification of coverage, you may be asked to pay in full or reschedule your visit for a time the verification can be obtained. This verification will be used to estimate your financial responsibility; however, this verification is not a guarantee by your health plan to pay for services received.

Payment of Patient Responsibility

Payment of your estimated patient responsibility is expected at the time services are rendered. This payment will include known deductibles, copays, and coinsurance amounts applicable for each visit and or procedure. While we may estimate your financial responsibility, it is your insurance company that makes the final determination regarding eligibility and benefits. For your convenience we accept cash, checks, most major credit cards and debit cards.

NSF Checks/Denied Credit Card Payments

You will be charged a $25.00 fee should a payment be returned for insufficient funds. This fee applies to payments made at our front desk, mailed in to the Business Office, electronically via the internet, or payments by phone.

Past Due Amounts

In the event your account becomes past due, and all efforts to collect payment have failed, your account may be referred to a collection agency.

Additional Services Identified During Treatment

Please be aware additional charges may be incurred if during the course of a physical exam a physician addresses, diagnoses, or treats problem-focused health concerns unknown at time of check in.

Non Covered Services

Please be aware certain office procedures or services may not be covered, or may be considered "not medically necessary", "experimental", "cosmetic", or simply "non-covered" by your health plan. You are responsible for payment of these services. In the event your care exceeds a plan limitation, you will be responsible for the balance. It is your responsibility to know the benefits and limitations of your current health care coverage. This clinic will provide medically necessary care based on patient's needs, not a patient's insurance coverage. This clinic is not responsible for knowing your plant's specific benefit and coverage limitations.

Third Parties Insurance

We do not file insurance claims to non-contracted third parties involving automobile accidents, accidental injury, property insurance, etc. You will need to pay in full at the Time of Service and file the claim with your insurance company. An itemized statement may be obtained by calling our business office. This statement will assist you with reimbursement. It is your responsibility to file claims in these instances.

Appointment Scheduling

Please be advised, as a courtesy, an automated service will call the primary phone number listed on file to remind you of your appointment date and time. You must notify the office within 24 hours of your scheduled appointment if you are unable to keep your appointment. Failure to notify the office within 24 hours may result in a $25.00 assessment to your account. Repeated failure to call and cancel your scheduled appointment without the proper 24 hour notice may result in your dismissal as a patient.

Forms/Medical Letters

We are happy to assist you by completing forms and generating medial letters for you upon your request. The fee for this service varies depending on the form or letter, but most do not exceed $25.00 per form. Payment is collected when you pick up the documents. Please allow 10 business days.

Medical Records

Requests for your medical records must be in writing via a special release form. Release of records is managed via an outside vendor. The cost is $25.00 for the 1st 20 pages and $.50 for each additional page. You will pay the outside vendor for these copies.

Office Hours

While appointment times vary for each provider, our office staff is available by telephone 8:00am to 5:00pm Monday through Friday. Because our providers and nurses are often tending to patients, it is typically necessary for you to leave a message. So we may assist you in a timely manner, please leave pertinent information to include the reason for your call and best number to call. We have an answering service to take your calls before and after our scheduled office hours.

- Emergency Needs – always call 911
- Prescription Refills – call during regular office hours and if leaving a message, provide your name, the medication, your pharmacy name, location, and phone number. Refills of controlled substances and/or narcotics MUST be filled by speaking with a medical staff member.

Authorization to Release Information

I hereby authorize CHI St. Luke's Health Medical Group to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of an examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked in writing.

Assignment of Benefits

I hereby assign all medical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct insurance carrier(s), include Medicare, Medicaid, private insurance and any other health/medical plan, to issue payment check(s) directly to CHI St. Luke's Health Medical Group for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Financial Responsibility

I acknowledge I have requested medical services from CHI St. Luke's Health Medical Group, on behalf of myself and/or my dependents and understand that by making this request I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I agree to pay CHI St. Luke's Health Medical Group for all services and products administered. I understand and acknowledge that any monies collected prior to the date services are rendered or products are administered will be applied as a deposit towards total charges assessed for the services rendered. The deposit shall not be considered payment in full. If I participate in a managed care plan, such as an HMO or PPO, I promise to pay for any services or products administered that are not covered under the plan as a result of inaccurate, incomplete or untimely patient information provided by me to the clinic and for any out-of-network charges.

I further understand that fees are due and payable on the date the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

My signature certifies I have read and understand the above content of this document.

_____	_____
Print Patient Name	Patient Date of Birth
_____	_____
Patient/Guardian Signature	Date