WASHINGTON COUNTY MEMORIAL HOSPITAL

Healthway Primary Care Austin Plaza Primary Care WCMH-Urgent Care Bonne Terre Medical Group Potosi Rural Health Clinic

Patient Registration Form

Patient Name_____ **Sex**: M / F **Date of Birth**_____ **SS#**_____

Mailing Address_____**City**_____**Zip Code**_____

Home Ph _____**Cell Ph**_____ **Status**: S M D W Separated **Smoker**: Y / N **Smokeless Tobacco**: Y/ N

Race: Oriental/Black or African American/White/Multi-Racial/Other/Decline **Ethnicity**: Hispanic / Non-Hispanic

Last Physician & Date_____ _____**Emergency Contact & Relation** _____**Ph #**_____

Patient Employer _____**Address** _____**Phone #**_____

Spouse_____ **Date of Birth**_____ **SS#**_____ **Spouse Employer**_____

Parent or Insured Party (if not parent)

Father/Stepfather_____ DOB_____SS#_____ Employer_____
Mother/Stepmother_____ DOB_____SS#_____ Employer_____
Guardian/Relationship_____ DOB_____SS#_____ Employer_____
Absent Parent_____ DOB_____SS#_____ Address & Ph #_____

Insurance (bring proof of insurance to each visit)

Primary Ins_____ Member ID#_____ Group#_____
Secondary Ins_____ Member ID#_____ Group#_____

Care Preferences

Pharmacy of Choice _____City_____ Ph# _____Fax #_____

Do we have your permission to:

- Leave a message on your answering machine or voice mail? Yes No
- Leave a message at your place of employment? Yes No N/A
- Discuss your medical condition with any member of your household? Yes No
- Discuss your medical condition with a specific friend or relative? Yes No
  If so, whom?_____ Relationship_____

Notification of Advanced Directives

Please indicate by initializing below if you have any of the following types of advanced directives to let your physician and family know what your desires for medical care are if you become unable to communicate them. If in place please provide a chart copy.

( ) Durable Power of Attorney for Health Care ( ) Health Care Choices Directive ( ) Living Will ( ) None

Authorization to Release Information and Assignment of Benefits

- I hereby give authorization for payment of insurance benefits to be made directly to WCMH - RHC and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.
- I further agree that a photocopy of this agreement shall be as valid as the original.
- I understand by signing below that I am giving permission for the Practice to deliver medical care to me.
- I acknowledge that I have been provided with WCMH-RHC's Notice of Privacy Practices.
- I authorize any holder of medical or other information about me to release to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or related MCR claim.
- I understand that it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment. (Section 1128B of SS act and 31 U.S.C. 3801-3812 provide penalties for withholding this information). Regulations pertaining to MCR assignments of benefits also apply.
- I understand that should I qualify for the Sliding Scale Program it is my responsibility to obtain the required information within the allotted time frame or the charges revert back to standard rates.
- Authorization to obtain medication list both current and inactive via pharmacy records, insurance company and or Sure Scripts.
- Some healthcare services at this facility may be offered via telemedicine. Potential risks of this technology include interruptions, unauthorized access and technical difficulties. I understand that telemedicine is a billable service from provider and a possible facility fee charge. Telehealth presenters may be present during my encounter to manager the cameras and perform any hands on activities to complete the exam. In emergent consultation, the specialist's responsibility will conclude upon the termination of the video conference connection.

List all legal guardians & relationship of minor for consent of treatment _____

Signature _____ Date_____