REGISTRATION FORM

LEGAL NAME

(Last)_____ (First) _____ (Middle) _____

Maiden Name If Applicable: _____ Social Security#: _____

Date of Birth: _____ Sex: M or F

Street Address_____ Mailing Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____

Email: _____
Please provide an email so you can get started with our secure patient portal! Through your portal account, you can view your test results, request appointments, ask us a question & more! Ask us for information.

Nickname: _____ Religion: _____ Church: _____

Race (circle one): White – Black - Asian – AM Indian – Alaska Native- – Native Hawaiian –Pacific Islander - Unknown Ethnicity (circle one): Hispanic/Latino Non Hispanic/Non Latino

Receiving Military Medical Benefits? Y or N Birthplace: _____ Unknown ☐
County or City AND State

Primary Language: English Spanish

Marital - (S) Single – (M) Married – (D) Divorced – (W) Widowed – (X) Separated – (P) Significant Other

TOBACCO/SMOKING HISTORY:
Smokeless Tobacco (moist)
Never used ☐ Ex-User ☐ Current User ☐

Smoker
Never smoked ☐ Former smoker ☐ Current Smoker ☐ - Heavy (10+ daily) ☐ Light (<10 daily) ☐
Smoking Start date: _____ Smoking End date: _____

Do we have your permission to access your electronic prescription history? Yes ☐ No ☐

Do you have: Living Will ☐ DNR ☐ POA ☐ Name of POA: _____

POA phone number: _____ Relationship to patient: _____

If you are eligible for Medicare

Are you eligible due to AGE ☐
Are you eligible due to DISABILITY ☐ Date of Disability _____ If Disabled, ever employed YES or NO

Are you currently in a Black Lung Program? YES or NO
Do you have End Stage Renal Disease (ESRD)? YES or NO

PATIENT EMPLOYER INFORMATION:
Employer Name: _____

Employer Address: _____

Employer City/ST/Zip: _____

Employer Phone: _____ Occupation: _____

If retired, Retirement Date: _____

SPOUSE INFORMATION:
(Last)_____ (First) _____ (Middle) _____

Social Security#: _____Date of Birth: _____ Sex: M or F

Home phone: _____ Cell: _____

Street Address_____Mailing Address: _____

City: _____ State: _____ Zip: _____

Spouse's Employer: _____Employer Phone:_____

Employer Address: _____

Employer City/ST/Zip: _____

If retired, Spouse's Retirement Date: _____

Is Spouse eligible for Medicare

Are you eligible due to AGE ☐
Are you eligible due to DISABILITY ☐ Date of Disability _____ If Disabled, ever employed YES or NO

BILLING INFORMATION:

Person who holds insurance (if other than patient):
(Last)_____ (First) _____ (Middle) _____

Social Security#: _____Date of Birth: _____ Sex: M or F

Relationship: _____Home phone: _____ Cell: _____

Street Address_____Mailing Address: _____

City: _____ State: _____ Zip: _____

Employer: _____Employer Phone:_____

Employer Address: _____

Employer City/ST/Zip: _____

EMERGENCY CONTACT (Not Living with patient)
(Last)_____ (First) _____ (Middle) _____

Maiden Name If Applicable: _____ Date of Birth: _____

Sex: M or F Relation to patient: _____

Street Address_____Mailing Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____

CONSENT TO RELEASE INFORMATION
I authorize Harrisburg Medical Center Clinics to discuss and release medical information regarding my care to the following persons/facilities. I may withdraw this authorization at any time with written notice to the office.

Name_____Relationship_____

Name_____Relationship_____

REVIEW THIS STATEMENT AS CONSENT FOR CLINIC TREATMENT.

Consent to Treatment: I am presenting myself to the hospital clinic and I voluntarily consent to the rendering of such care including diagnostic procedures and medical treatment, by authorized agents and employees of the hospital clinic, and no guarantees have been made to me as to the effect of such examination or treatment on my condition. I realize that during the course of my care at the Harrisburg Medical Center Clinic or for follow-up care, it may be necessary for the Clinic, Hospital, or my attending physicians to make available to other health care providers, copies of my medical records for information relating to my care, and I consent to such release.

SIGNATURE_____DATE_____TIME_____

NO-SHOW APPOINTMENT POLICY

I understand it is important for me to keep scheduled appointments with my provider at Harrisburg Medical Center Clinics. Failure to present to my scheduled appointment prevents myself or another patient with medical needs from being seen. I understand by signing this document, I acknowledge and agree to the terms of the policy set forth by my provider. I understand failure to comply with the guidelines and provide a minimum of a **24 hour** notice to my provider's office will result in a no-show appointment fee incurred to my account. I further acknowledge I will be solely responsible for the fee assessed to my account for no-show appointments and understand this fee must be paid before my next visit to a provider with Harrisburg Medical Center Clinics.

SIGNATURE_____DATE_____TIME_____

MEDICARE PATIENTS ONLY: Please sign for lifetime authorization.

I authorize Harrisburg Medical Center Clinics to release to the Health Care Financing Administration and Social Security Administration or it's intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Harrisburg Medical Center Clinics or the party who accepts assignment.

SIGNATURE_____DATE_____TIME_____

FINANCIAL AGREEMENT AND PAYMENT GUARANTEE:

I, the undersigned, assign directly to Harrisburg Medical Center and it's Clinics, all surgical and/or medical benefits rendered. I understand that I am FINANCIALLY RESPONSIBLE for all charges by the clinic or hospital whether or not paid by insurance or if you are not on our Illinois Health Connect roster. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. Both undersigned patient and the guarantor(s) agree that in consideration of the services to be rendered to the patient, they hereby individually obligate themselves to pay the charges of the hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate. **By signing below, you are authorizing the hospital, its providers or agents, and debt collectors to make calls or send text messages by artificial or pre-recorded voice messages and/or auto-dialer to any number you provide including residential landlines and mobile, cellular, or similar devices for any lawful purpose.** You agree to any fees or charges that you may incur for incoming calls from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

SIGNATURE_____DATE_____TIME_____

Harrisburg Medical Center
Acknowledgement of Receipt of
Notice of Privacy Practices

You May Refuse To Sign This Acknowledgement

☐ I have received a copy of the Notice of Privacy Practices

_____ _____
Please Print Patient's Name Date of Birth

_____ _____
Parent or Legal Guardian (if minor patient) Relationship

_____ _____ _____
Signature – Patient or Legal Guardian Date Time

**********FOR HOSPITAL STAFF USE ONLY**********

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign.

☐ Communication barriers prohibited obtaining the acknowledgment.

☐ An emergency situation prevented us from obtaining acknowledgment.

☐ Other (Please specify)

_____
_____
_____
_____

_____ _____ _____
Signature of Staff Member Completing This Section Date Time

Tobacco/Smoking History of patient:

Smokeless Tobacco (moist): Never used Ex-User or Current User

Smoker: Never Used Ex-User or Current User If Current user: Heavy (10+ daily) or Light (<10 daily)

Smoking start date:_____ Smoking End date:_____

If patient is no longer employed, please list retirement date:_____

Do we have your permission to access your electronic prescription history? Yes or N

Do you have a Living Will ☐ DNR ☐ POA ☐ Name of POA:_____

POA phone number:_____ Relationship to patient:_____

Spouse Information:

(Last)_____ (First)_____(Middle)_____

Social Security#:_____ Date of Birth:_____ Sex: M or F

Phone #:_____

Spouse's Employer:_____ Employer's Phone:_____

Employer's Address:_____ City:_____ State:_____

If retired, Spouse's Retirement Date:_____

Is Spouse eligible for Medicare

Is your spouse eligible due to AGE or DISABILITY Date of Disability:_____

Consent To Release Information

I authorize Harrisburg Medical Center Clinics to discuss and release medical information regarding my care to the following persons/facilities. I may withdraw this authorization at any time with written notice to the office.

Name_____ Relationship_____

Name_____ Relationship_____