REGISTRATION FORM (Minors)

LEGAL NAME

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

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

Street Address_____ Mailing Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____

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

Birthplace: _____ Unknown ☐
County or City AND State

Primary Language: English Spanish

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 ☐

GUARANTOR INFORMATION:
(For patients under the age of 18)
(Last)_____ (First) _____ (Middle) _____

Maiden Name If Applicable: _____ Social Security#: _____

Date of Birth: _____ Sex: M or F Home phone: _____ Cell: _____

Street Address_____ Mailing Address: _____

City: _____ State: _____ Zip: _____

***FATHER*:**
(Last)_____ (First) _____ (Middle) _____

Social Security#: _____Date of Birth: _____Sex: M or F

Street Address_____Mailing Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____

Employer:_____ Employer phone:_____

Address:_____

City:_____State: _____ Zip: _____

***MOTHER*:**
(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: _____

Employer:_____ Employer phone:_____

Address:_____

City:_____State: _____ 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_____

GUARANTOR SIGNATURE _____DATE _____TIME_____
(if minor)

_____
PRINT NAME OF GUARANTOR

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.

GUARANTOR SIGNATURE _____DATE _____TIME_____
(if minor)

_____
PRINT NAME OF GUARANTOR

FINANCIAL AGREEMENT AND PAYMENT GUARANTEE:

I, the undersigned, assign directly to Harrisburg Medical Center and its 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_____

GUARANTOR SIGNATURE _____DATE _____TIME_____
(if minor)

_____
PRINT NAME OF GUARANTOR

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

CONSENT TO TREAT A MINOR CHILD

I, _____, (_____) authorize HMC Clinic Services and any
Print Name of Parent/Guardian Relationship

Provider(s) employed or contracted by HMC Clinic Services to provide Medical and/or Behavioral Health treatment to my child, _____ in my absence.
Print Name of Child

This authorization expires 1(one) year from the date signed below.

Parent's Signature	Date	Time
Witness Signature	Date	Time
Witness #2 Signature *(if consent is given over the phone*)	Date	Time