Patient Registration Form

Horizon Healthcare School & Sports Physicals

Patient information:

Legal Name: _____

FIRST MIDDLE LAST

Patient's Date of Birth: _____ Age: _____ Gender: _____

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Doctor: _____

Guarantor Information:

Parent or Legal Guardians Name: _____

Relationship to patient: _____ Date of Birth: _____

Address (If Different from patient): _____

City: _____ State: _____ Zip: _____

Emergency Contact:

Name: _____

Relationship: _____ Phone Number: _____

Insurance Information: (Please include Payor name, Policy number, and Policy holders information)

Primary Insurance: _____

Secondary Insurance: _____

Signature: _____ Date: _____

Relationship to Patient: _____

FAIRFIELD MEMORIAL HOSPITAL
FAIRFIELD, ILLINOIS

ASSIGNMENT OF INSURANCE BENEFITS: I represent that I presently maintain medical insurance coverage which will reimburse the charges for the hospital and medical care being provided. If my medical insurance coverage is not sufficient to satisfy the hospital charges in full, I acknowledge that the resulting balance is not covered by this Assignment and I will be fully responsible for payment of this balance due upon receipt of patient bill as consideration for hospital and medical services rendered, and I agree to pay the established rates of Fairfield Memorial Hospital and its physicians or independent contractors for all services, facilities and supplies rendered.

In consideration of those hospital and medical services rendered by Fairfield Memorial Hospital, I hereby assign, transfer and set over to Fairfield Memorial Hospital all of my rights, title and interest to medical reimbursement, and all other rights and privileges including, but not limited to, the right to designate a beneficiary, add dependent eligibility and to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by Fairfield Memorial Hospital.

FINANCIAL AGREEMENT: I, the undersigned, agree, whether signing as an agent or as the patient, that in consideration of the services to be rendered to the patient, to pay the account of the patient in accordance with the regular rates and terms of the hospital within 30 days upon receipt of the patient bill. Should the account be referred to an attorney and/or collection agency for collection, the undersigned shall pay all court costs, collection agency fees, attorney fees, and all other expenses incurred with collection. I agree that I may be contacted by telephone at any telephone number associated with my account, including wireless (cellular) telephone numbers, which could result in additional charges to my phone bill. Provider reserves the right to decline further services to the patient without notice; to accept periodic installment payments without waiving its rights to demand payment in full; and the right to assign the monies due. This assignment shall be binding upon all heirs, personal representatives and successors. I further authorize the hospital to apply any overpayment on any accounts to any other unpaid accounts that I or my guarantor have.

PRE-CERTIFICATION REQUIREMENTS: If my insurance company or third party payor requires pre-certification, I understand that it is my responsibility to contact them to obtain authorization for services.

I have had the opportunity to discuss this form and understand the contents.

A copy of this signature is as valid as the original. Authorization is valid from this date forward unless revoked. Authorization shall also apply for any physician services for whom the hospital is authorized to bill.

PATIENT SIGNATURE _____
I, the undersigned, am the patient, and hereby consent to and accept the terms of the above.

OTHER SIGNATURE _____
I, the undersigned, hereby certify, that the patient is unable to grant consent or is a minor and I, the undersigned, hereby consent to and accept the terms of the above as agent, guardian, parent, committee or attorney in fact.

Implied Consent: _____ Verbal Consent: _____

_____	_____	_____
Patient/Legal Signature	Relationship	Date

_____	_____
Witness	Date

CONSENT FOR MEDICAL TREATMENT: I request and authorize my physician and any other physicians consulted upon my behalf and Fairfield Memorial Hospital and its employees and agents who attend me, to provide and perform such medical care, tests, examinations, treatment, anesthesia, procedures, administer drugs and provide other services and supplies as are considered advisable for my health and well-being. I acknowledge that the practice of medicine is not an exact science and that no guarantee has been given to me by anyone as to the results of treatments or medical care performed in the hospital. I acknowledge and understand that physicians, consultants, surgeons, hospital-based physicians such as pathologists, radiologists, emergency physicians, and non-physician providers, who provide services at Fairfield Memorial Hospital are not employees or agents of Fairfield Memorial Hospital, but instead are independent medical practitioners or contractors. **I acknowledge that the employment or agency status of physicians and other providers who treat me is not relevant to my selection of Fairfield Memorial Hospital for my care.** This consent includes testing for blood-borne infectious disease(s), including but not limited to Hepatitis and Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) if a physician orders tests for diagnostic purposes.

PERSONAL PROPERTY (Money and Valuables): The undersigned certifies that the patient is advised to send all monies and valuables home and if that is not possible, to deposit monies and valuables with the hospital for safe keeping. The patient is further advised that the hospital cannot accept any liability for such monies and other valuables of whatever nature that the patient might take, or have, on the patient floor.

RELEASE OF INFORMATION: I authorize Fairfield Memorial Hospital to notify my referring physician, if any, of my admission to the hospital and to release any information about me as requested by my referring physician. I authorize the hospital to release medical information, financial information and hospital medical records to the following persons or groups: (a) any third party payor which is or may be liable to the hospital or my physician for all or part of their charges, including but not limited to insurance companies, worker's compensation carriers, the Social Security Administration or its intermediaries, or my employer; (b) any person or entity for peer review, quality management or utilization review; (c) any person or entity for scientific, educational, research or statistical purposes, including but not limited to the Cancer Registry; (d) any physician or medical provider who provides care or services to me. **This includes information relative to substance abuse (including but not limited to alcohol or drugs), psychological or psychiatric conditions and Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency virus (HIV).**

COMMUNICATION OPT-IN: I agree that I may be contacted by telephone at any telephone number associated with my account, including wireless (cellular) telephone numbers, to include appointment text reminders, which could result in additional charges to my phone bill.

MEDICARE INPATIENTS ONLY: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I acknowledge that I have received a copy of "An Important Message from Medicare". My signature only acknowledges my receipt of this message and does not waive any of my rights to request a review or make me liable for any payment.

* *

A copy of this signature is as valid as the original.

PATIENT SIGNATURE _______
I, the undersigned, am the patient, and hereby consent to and accept the terms of the above.

OTHER SIGNATURE ________
I, the undersigned, hereby certify, that the patient is unable to grant consent or is a minor and I, the undersigned, hereby consent to and accept the terms of the above as agent, guardian, parent, committee or attorney in fact.

Implied Consent: ___________ Verbal Consent: ____________

Patient/Legal Representative Signature | Relationship | Date | Time

Witness | Date

BUS-ADMIT-1 (Rev 10/25) (w)

FAIRFIELD MEMORIAL HOSPITAL
Fairfield, Illinois

ACKNOWLEDGEMENT OF LEGAL RELATIONSHIP

I understand that Fairfield Memorial Hospital Association (FMH) employs the following practitioners:

Christopher Ballard, MD	Ross Herdes, APN FNP	Vicki Wyatt, APN FNP
Frances Guerra-Bauman, MD	Amber Loya, APN FNP	Alexis King, CRNA
Marla Lafikes, MD	Sherry Mewes, APN FNP	Kimberly King, CRNA
Lauren Williams, MD	Priscilla Poore, APN FNP	Betty Sagovac, CRNA
Kayla Bell, PA-C	Lavada Simpson, APN FNP	Mason Spitzner, CRNA
Kristen Harris, PA-C	Jennifer Smith, APN FNP	Benjamin Curtis, CRNA
Deandra Thompson, PA-C	JoAnn Smith, PMHNP	Thomas Falcone, CRNA
Jackie Crawford Camp, APN FNP	D. Wayne Stennett, APN FNP	John Wall, CRNA
Erica Fearday, APN FNP	Misty Stone, APN FNP	Amy Barton, LCSW
John Gilmore, APN FNP	Stephen Welty, APN FNP	Lauren Griswold, LCSW

Please initial each line below in acknowledgment of these informational notices:	
	I acknowledge and understand that physicians, consultants, surgeons, hospital-based physicians such as pathologists, radiologists, emergency physicians, anesthesiologists, and non-physician providers such as surgical vendor representatives, who provide services at Fairfield Memorial Hospital, are not employees or agents of Fairfield Memorial Hospital, but instead are independent medical practitioners or contractors.
	I understand that each of these providers exercises his or her own, independent medical judgment and is solely responsible for the care, treatment, and services that he or she orders, requests, directs, or provides.
	I acknowledge that the employment or agency status of physicians and other providers who treat me is not relevant to my selection of Fairfield Memorial Hospital for my care.
	I also understand that I will receive, am solely responsible for payment of, a separate bill from each of these independent practitioners, or groups of practitioners, for care, treatment, or services provided.

These independent contractor physicians and groups include:

Rodney Beeler, MD Douglas Frankel, MD P. Gabriel Gomez, MD James Gruber, MD Kyle Kakac, MD Jasiri Kennedy, MD Mark Rotich, MD Scott Roustio, MD Ronald Johnson, MD Steven Mitchell, MD Mark Murfin, MD Karishma Habbu, MD	Cancer Care Specialists of Southern Illinois – Gibran Mahmud, MD; Kristi Toennies, APN FNP; and Bassam Maalouf, MD
	Specialists in Medical Imaging, S. C. , Radiology Partners Saline Valley Division – All Radiologists are independent providers and are not employees or agents of the Hospital
	Deaconess Heart Group – All Cardiologists are independent providers and are not employees or agents of the Hospital
	Sarah Bush Lincoln Pathology – All Pathologists are independent providers and are not employees or agents of the Hospital
	Patrick Molt, MD, Southern Illinois Surgical Care Associates
	Page Foot and Ankle – Jennifer Miller DPM

I acknowledge that any questions about this Independent Contractor Disclosure form and the important information contained within it have been answered to my satisfaction

_____
Signature of Patient / Legal Representative

_____
Relationship to Patient

_____
Witness

Fairfield Memorial Hospital
Fairfield, Illinois

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Fairfield Memorial Hospital reserves the right to modify the privacy outlined in the notice.

By signing below, I acknowledge that I have received a copy of the Privacy notice for Fairfield Memorial Hospital.

_____ _____
Name of Patient (Print or type Date:

_____ _____
Signature of Patient Date:

_____
Signature of Patient Representative
(*Required if the patient is a minor or an adult who is unable to sign this form*)

_____
Relationship of Patient Representative to Patient

_____ Unable to obtain signature due at the time of registration due to emergency treatment. Privacy notice was still given to patient/patient representative and an attempt will be made after the situation is resolved to obtain signature. Please describe emergency situation._____

_____

_____

_____ _____
Staff Signature Date:

Follow-up to obtain signatures after the emergency situation has been resolved:

_____ _____
Patient/Patient Representative Date:

_____ _____
Staff Signature Date:

To be retained for six years from date of signature

FMH-MISC-28 (10-11)(w)