HERINGTON HOSPITAL
A Community of Care.

Patient Registration Form

Full Name			
SSN#	**Date of Birth (MM/DD/YY)**	**Gender at Birth** M F	
Address	**City**	**State**	**Zip Code**
Mailing Address (If different from address)	**Mailing City**	**Mailing State**	**Mailing Zip Code**
Home Phone	**Cell Phone**	**Work Phone**	
Additional/Former Names (Ex. Maiden Name)		**Marital Status** ☐ S ☐ M ☐ D ☐ W	
Email Address (Required for Patient Portal Access)			

Pharmacy ☐ Herington Hospital Pharmacy ☐ Kay's Pharmacy ☐ Other Pharmacy (specify):_____

Race	Do you identify as Hispanic/Latino?
☐ American Indian/Alaska Native	☐ Yes
☐ Asian	☐ No
☐ Black/African American	**Preferred Language**
☐ Native Hawaiian	☐ English
☐ Other Pacific Islander	☐ Spanish
☐ White/Caucasian	☐ Other: _____
(Check all that apply)	☐ Interpreter Needed

Complete If Patient Is Under 18 Years of Age

Mother's Name	**Mother's Date of Birth**
Father's Name	**Father's Date of Birth**

Person Responsible for Bill ☐ Check if same as patient

Full Name			
SSN#	**Date of Birth**		
Address	**City**	**State**	**Zip Code**
Home Phone	**Cell Phone**		
Email Address	**Employer**		

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Patient Name	Date of Birth

Emergency Contact

☐ *Check here if this person can also receive medical information for you

Name	Phone	Relation

Family Members Whom We Can Release Medical Information To

Name	Phone	Relation

Patient Acknowledgement– Notice of Privacy Practices & Patient Rights and Responsibilities

I acknowledge that Herington Area Health Clinic (HAHC) has given me the right to review and secure a copy of the Notice of Privacy Practices as well as the following documents, which describes how health information about me may be used and disclosed, as well as a complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that HAHC reserves the right to change the terms of this notice periodically, and that I may contact HAHC at any time to obtain the most current copy of these documents. I understand that if I have any questions regarding any of these documents, I can contact HAHC.

I acknowledge that Herington Area Health Clinic (HAHC) has given me the right to review and secure a copy of the patient's rights and responsibilities. I understand that if I have any questions regarding my rights, I can contact Herington Area Health Clinic.

A paper copy may be obtained at the front desk

◊ Payment Agreement

◊ Insurance Filing/Medicare

◊ Attendance Agreement

◊ Notice of Privacy Practice

◊ Patient Rights and Responsibilities

I have answered the information above to the best of my knowledge and ability. I have been given the opportunity to review, and I fully understand, and accept, all terms and policies stated above.

I authorize the release of any medical information necessary to process this claim and any/all future claims. I agree to pay all collection fees, interest, court fees, interest, court costs, and attorney fees should my account become delinquent or be sent to collections. I authorize payment of said medical benefits be made directly to the physician/supplier that is noted on my claims. A photo static/faxed copy of this authorization will be as valid as the original. I certify that all above information is true and correct. This information is being collected in accordance with section 27 of the Health Information Act and protects the confidentiality of this health information and your privacy.

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

☐ **Patient/Parent or Guardian refuses to Acknowledge Receipt of Privacy Practices:**

_____ _____ _____

HAHC Staff Name (PRINT) HAHC Staff Signature Date

This area is to ***only*** be filled out by a Herington Area Health Clinic Staff member, if patient needed help filling out this form and patient or patient's legal representative is present.

_____ _____ _____

HAHC Staff Name (PRINT) HAHC Staff Signature Date

Herington Area Health Clinic
1005 N. B Street
Herington, KS 67449
P: 785-258-5130 F: 785-258-5129

Family Health History

Patient: _____ **D.O.B.** _____ **Date:** _____

Please review listed the diseases and conditions listed below, and indicate those that are a health problem for your family members. Leave the spaces blank that do not apply. If you require more space, please use the back side of this paper.

Please indicate Paternal (P) or Maternal (M) in the Grandparent Column.

	Father	Mother	Brother(s)	Sister(s)	Children	Grandparent
Deceased Age						
Condition						
Arthritis						
Asthma						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Depression/Anxiety						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
Hypertension						
Insomnia						
Kidney Condition						
Liver Condition						
Migraine						
Nervousness						
Scoliosis						
Sinus Issues						
Stomach Issues						
Other:						

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Patient: _____ **D.O.B.** _____ **Date:** _____

Mammo Date: _____ **Colonoscopy Date:** _____ **PAP/Pelvic Date:** _____

Patient Problem List:

_____
_____
_____
_____
_____
_____

Surgeries	Surgeon	Location	Date

Social History:

Highest Grade Completed: _____ Profession: _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How much caffeine do you drink per day (in cups)? _____ Do you use tobacco: ☐ Y ☐ N **If Yes**, how many cigarettes per day?_____

How often do you consume alcohol? ☐ Never ☐ Occasionally ☐ Socially ☐ Often ☐ Daily

Do you have a current or past history of drug abuse? ☐ Y ☐ N **If Yes**, what type of drug(s)? _____

Do you have a current or past history of STD? ☐ Y ☐ N **If Yes**, what type of STD(s)?_____

Have you had an abnormal PAP? ☐ Y ☐ N **If Yes**, when? _____

Vaccinations/Date:

Pneumovax:	Influenza:	TB Test:	Tetanus:

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Patient: _____ **D.O.B.** _____ **Date:** _____

Pharmacy: ☐ Herington Hospital Pharmacy ☐ Kay's Pharmacy ☐ Other: _____

ALLERGIES:

_____
_____
_____
_____
_____

Medication Name	Dosage

Herington Area Health Clinic

FINANCIAL POLICY

Herington Area Health Clinic believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

PAYMENT is expected at the time of your visit. We accept payment by cash, check, VISA, and MasterCard. We do accept payments on-line on our website at www.heringtonhospital.org (http://www.heringtonhospital.org/). Payment will include any unmet deductible, co-insurance, co-payment, or non-covered charges from your insurance company. All previous balances must be paid at time of service, unless prior arrangements have been made with the billing department. We do ask for a copy of an ID card of license due to the many cases of identity theft in the news lately. (Please do not be offended!)

INSURANCE We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.

If our providers are not listed in your plan's network, you may be responsible for partial or full payment. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and providers before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

Patients who insist on "day of" urgent/emergent scheduling will be assessed an additional urgent care or after hours fee. These fees will be billed to your insurance carrier or collected as part of the office charges for self-pay patients.

RETURNED CHECKS will incur a $30.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the provider. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Dickinson County.

ACCOUNTING PRINCIPALS Payments and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

FORMS FEES Completing insurance forms, copying medical records, etc… Requires office staff time and time away from patient care for our providers. We require pre-payment for completing forms, copying medical records, or for extra written communication by the provider and will have 7 business days in which to complete. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $10 per occurrence plus and applicable postage fee. Postage is additional and payment is required in advance. Copying fees for Medical Records is an initial charge $18.97, the first 250 pages will be $0.63; additional pages will be $0.45. Herington Area Health Clinic will have 15 business days in which to copy records before making them available for patient to pick up, and these 15 days will commence after payment for the copying has been received and after patient has signed this form authorizing records' release.

BILLING OFFICE If you have questions in regard to any of your billing statements, our billing department staff is available to assist you. **CALL 785-258-2207**

CANCELLATIONS OR MISSED APPOINTMENTS If you do not cancel your appointment at least 24 hours before, or if you no-show 3 time we will discharge you from our clinic.

RESPONSIBILITY FOR PAYMENT I understand that I, personally, am financially responsible to **HERINGTON AREA HEALTH CLINIC** for charges not covered by the assignment of insurance benefits.

ASSIGNMENT OF INSURANCE BENEFITS I hereby assign, transfer, and set over directly to **HERINGTON AREA HEALTH CLINIC** sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize **HERINGTON AREA HEALTH CLINIC** to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Herington Area Health Clinic. I authorize **HERINGTON AREA HEALTH CLINIC** to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

SELF PAY PATIENTS OR PROMPT PAY PATIENTS WHO ARE INSURED A minimum $50 payment for existing patients and new patients is due prior to treatment from all uninsured patients. You will have 60 days to pay your balance in full. You will receive 30% discount if paying your entire balance that day. This means anyone willing to/or needing to pay in full at the time of service will receive the 30% discount off of the evaluation and management service codes only. Charges for supplies, test, immunizations, medications, or procedures are never discounted. The balance is the best estimate and there could be additional charges after your visit. A 30% prompt pay discount is applied to all full pay payments received at the time of service whether or not you carry insurance.

RELEASE OF INFORMATION I hereby authorize the and direct **HERINGTON AREA HEALTH CLINIC** to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

COLLECTION FEES I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collection agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

DIVORCED PARENTS of PATIENTS By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment of communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues. The following parties are responsible for payment of all minor patient balances: the adult accompanying the minor and the parents (or guardians.). We do not recognize domestic judgments including custody agreements.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of Patient (or Guarantor, if applicable) Date

_____

Please print the name of the patient

Herington Area Health Clinic – 1005 North B Street – Herington, KS
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HERINGTON AREA HEALTH CLINIC

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PLEASE MAIL IF RECORDS ARE MORE THAN 25 PAGES

(One Per Request)

PATIENT'S FULL NAME (PRINT): _____

OTHER NAMES USED (i.e. maiden name, nick name, etc.): _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

Release Information *FROM:*	Release Information *TO:*
Hospital or Clinic: _____	Hospital or Clinic: _____
Provider Name: _____	Provider Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

The purpose of this disclosure is: ☐ Continuation of Care ☐ Switching Providers ☐ Other

This authorization shall remain in effect until _____ (date) at which time this authorization to disclose the identified health information expires, but no later than one year from the date listed below. If left blank the authorization will shall remain effective for 60 days after the date listed below.

I understand that my health information may contain information relating to HIV, contagious diseases, psychiatric treatment, mental health treatment, substance abuse treatment, or other conditions which may be specifically protected by law, and I authorize disclosure of that information. I understand that once my health information has been disclosed, it will no longer be subject to federal privacy regulations and may be redisclosed by the person receiving it.

I, undersigned, have read the above and authorize the disclosure of such health information as described. I understand that:

- ✦ Treatment is not conditions upon the execution of this authorization.
- ✦ Fees may be charged for preparing and sending copies of records, including a charge for labor and supplies of up to $18.97 per request, a copying charge of $0.63 for the first 250 pages and $0.45 for additional pages, and the reasonable cost of all duplications of records that cannot be routinely duplicated on a standard photocopy machine.
- ✦ I may see and copy the information described on this form as provided by federal regulations, and that I will get a copy of this form after I sign it.
- ✦ I may revoke this authorization at anytime by providing written notice to the person listed as follows by mailing or hand delivering written notification to the following:
  Privacy Officer, Herington Hospital Inc., 100 E. Helen St., Herington, KS 67449

_____ _____
Signature of Individual or Individual Representative *Date*

_____ _____ _____
Printed Name of Representative *Relationship* *Telephone Number*

_____ _____
Witness Signature *Date*

FOR OFFICE USE ONLY:

PLEASE SELECT ALL THAT APPLY:

- ☐ Pap
- ☐ Medication List
- ☐ Problem List
- ☐ Allergies
- ☐ Last 4 Office Visits
- ☐ Mammogram
- ☐ Colonoscopy
- ☐ Most Recent Imaging
- ☐ Most Recent Lab Work

☐ **ONLY the specified dates/information:**

From: _____ **To:** _____

Kansas SB 119 mandates that all authorizations are no longer valid after one year from the date of signature.