The Christ Hospital Health Network

THE CHRIST HOSPITAL PHYSICIAN DIVISION

PATIENT REGISTRATION INFORMATION R-7230 REV. 4/19 PAGE 1 OF 2

Today's Date: _____

Patient Information: (please print)

Legal Name: _____
Last First Middle Initial

Social Security Number: _____ Preferred Name: _____ Date of Birth: _____

Legal Sex*: ☐ Male ☐ Female ☐ Unknown
*Legal Sex is what is listed on your IDs such as Driver's License, passport, green card, insurance card, etc.

Sex assigned at birth: ☐ Male ☐ Female ☐ Unknown ☐ Uncertain ☐ Not Recorded on Birth Certificate ☐ Choose not to disclose

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female
☐ Self Reported: _____ ☐ Choose not to disclose

Sexual Orientation: ☐ Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Don't Know ☐ Something Else ☐ Choose not to disclose

Address: _____
Number Street City State Zip

Home #: (___) _____ Work #: (___) _____ Cell #: (___) _____

Email Address: _____ Marital Status: S___ M___ D___ W___ Separated___ Partner___

Language Spoken (patient): _____ Language Spoken (caregiver): _____

Need Interpreter: Y___ N___

Religion: _____ Family/Primary DR.: _____

Race: White___ African American___ American Indian___ Asian___ Native Alaskan___ Native Hawaiian___ Refused___ Other_____

Ethnicity: Non-Hispanic_____ Hispanic_____

Employment Information: Retired: Y N Retirement Date: _____

Patient's Employer: _____ Patient's Occupation: _____

Insurance Information:

Primary Ins Name/Claims Address: _____

Policy/ID#: _____ Group #: _____ Patient Relationship to Subscriber: Self___ Spouse___ Child___ Other_____

Subscriber Info: Name: _____ DOB: _____ SSN#: _____

Employer: _____ Work #: (___) _____

Secondary Ins Name/Claims Address: _____

Policy/ID#: _____ Group #: _____ Patient Relationship to Subscriber: Self___ Spouse___ Child___ Other_____

Subscriber Info: Name: _____ DOB: _____ SSN#: _____

Employer: _____ Work #: (___) _____

Do you have a Living Will or Health Care Power of Attorney? Y___ N___

Have we received a copy? Y___ N___

Please Print:

Parent's or Legal Guardian's Legal Name: _____
(If applicable) Last First Middle Initial

Date of Birth: _____ SSN#: _____

Today's Date: _____

Patient's Legal Name: _____ _____
Last First Middle Initial Date of Birth

Contacts: In the event you are incapacitated or a minor, we may be required to contact your Healthcare Power of Attorney (POA) or Legal Guardian regarding your health information.* Please list any of the following:

Legal Guardian Name: _____ Phone( ) _____

Healthcare POA Name: _____ Phone( ) _____

Other Contacts: In the event we are unable to reach you, we are permitted to discuss or release your health information* to the following:

Name: _____ Name: _____

Relationship to Pt: _____ Relationship to Pt: _____

Home #: ( ) _____ Home #: ( ) _____

Work #: ( ) _____ Work #: ( ) _____

Cell #: ( ) _____ Cell #: ( ) _____

*health information includes, but is not limited to, your information regarding test results, prescription refills, billing questions, and in cases of emergency.

May we leave messages/test results on your answer machine? Y N

May we call you at your place of employment? Y N

The following may pick up my written prescriptions for controlled substances:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

We are legally required to provide you with a copy of our NOTICE OF PRIVACY PRACTICES the first time you receive care at TCHP. If you are here for emergency medical treatment, you will be given a copy as soon as possible.

❑ I received a copy of the Notice of Privacy Practices.

❑ I have previously received a copy of the Notice of Privacy Practices.

❑ I do not want a copy of the Notice of Privacy Practices.

AUTHORIZATION OF MEDICAL AND RELATED HOSPITAL SERVICES

1. CONSENT TO TREATMENT: I hereby consent to the administration of medical, nursing or other treatment, drug therapy and/or testing as considered necessary for my condition as directed by The Christ Hospital Physicians ("TCHP") or assistants or designated as may be needed. I understand and agree that interns, residents, fellows, nurses, medical students and other health personnel in training may participate with or assist my doctor(s) in the performance of medical, surgical or diagnostic procedures/treatment that my doctor(s) consider necessary.
2. RELEASE OF RECORDS: I authorize the release of medical records information (including but not limited to information concerning drug related conditions, alcoholism, psychiatric conditions, HIV testing, AIDS diagnosis/related conditions) to insurance carriers, third-party payers or their representatives, and/or review organizations as deemed necessary to determine benefits entitlement and to process payment claims for health services provided. I also understand my records may be released to state, federal or other surveyors for accreditation and/or regulatory licensing purposes. I authorize the release of medical record information to the physician(s) or agency for my follow-up care, and/or to the healthcare facility to which I am transferred. I authorize TCHP to access, release, and share accessible electronic medical information with other medical providers who utilize an electronic medical record system compatible with TCHP's system. I also authorize release of my medical record information as required or permitted by law.
3. FINANCIAL AGREEMENT: The undersigned agrees that, in consideration of the services to be rendered to the patient, I will pay the amount of the physician charges in accordance with TCHP's regular rates and terms. I hereby authorize TCHP to submit a claim to my insurance carrier(s) or its intermediaries to issue payment directly to TCHP on behalf of such rendered services. If TCHP is out of network with my insurance, my insurance provides only limited benefits, or my insurance denies payment to TCHP ("Lack of Coverage"), I understand that I am financially responsible to TCHP for any balance not covered by my insurance . I understand that it is my responsibility, not TCHP's responsibility, to address Lack of Coverage with my insurance company. I authorize TCHP to apply any credit balances to balances owed to The Christ Hospital.
4. COMMUNICATING WITH YOU: Consent to contact by electronic and other means. TCHP, its employees, its affiliates, and the vendors, agents, contractors, collectors, successors, and assigns of TCHP and its affiliates (collectively, "TCHP"), may contact me for any lawful reason, including for the collection of amounts owed to TCHP and for the offering of products or services in compliance with applicable privacy policies and requirements that are in effect from time to time. No such contact will be deemed unsolicited. By signing below, I authorize and voluntarily consent to TCHP contacting me: (i) at any address (including email) or telephone number (including wireless cellular telephone or ported landline telephone number) that I provide, have provided, or that was provided on my behalf to TCHP; (ii) using any means of communication (including but not limited to postal mail, electronic mail, telephone, text, messaging or other technology, collectively "Communication")) to reach me; and (iii) using automated dialing systems and announcing devices and playing recorded messages. I understand TCHP may, at times, use unencrypted or unsecured means of Communication to reach me, which I understand may create some level of risk that the information could be read by a third party, but I opt into receiving such Communications.

I understand and agree that I will contact The Christ Hospital HIM/Medical Records Department to ask that TCHP not contact me using any one or more methods or technologies by writing to us at 2139 Auburn Avenue, Cincinnati, OH 45219, calling us at 513-263-8660 should if I revoke this consent to communicate with me. I understand that my receipt of healthcare treatment and services is not conditioned upon my agreement to this provision.

_____ _____
SIGNATURE OF PATIENT (if 18 years or older) OR LEGAL GUARDIAN IF PATIENT IS A MINOR Date/Time