HORIZON
HEALTHCARE
Caring Through A Lifetime.

CHRISTOPHER BALLARD, MD
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D. WAYNE STENNETT, APN FNP
JILL BARNFIELD LCSW
BECKY AUGUST LCSW

Thank you for choosing Horizon Healthcare! We look forward to providing your medical needs.

Please arrive 30 minutes before your appointment time of on Arriving early allows time for staff to prepare your information for Dr. . Please complete all enclosed paperwork to the best of your ability. The registration desk is located near the front lobby of the Medical Arts Complex. The front desk will need the first few forms enclosed. The Patient Medical History Form will be reviewed by the nurse at your appointment.

PLEASE DO NOT MAIL THE FORMS BACK TO THE OFFICE. We may not receive them in time for your appointment.

We also ask that you bring the following: (these items will become part of your medical record)

*Driver's License or Photo I.D. *Insurance Cards
*Notarized "When You're Not There Form" if patient is a minor under 18 years of age
*A copy of your Advanced Directives (example - Power of Attorney, Living Will, DNR, etc)
*Medications you are currently taking (please bring in pharmacy bottles)
-Pills, Drops, Lotions, Supplements, etc.

Payment of your deductible or co-insurance is expected at your visit. We accept cash, check, debit, or credit. If you have any questions between now and your appointment, please do not hesitate to contact us at 618-842-4617.

Sincerely,

Horizon Healthcare, Medical and Support Staff

**Please note: It is the policy of Horizon Healthcare that after two New Patient rescheduled or cancelled appointments, we will not schedule additional appointments. If you do, however, need to cancel or reschedule, please do so at least 24 hours before your scheduled appointment. Thank you!

213 NW 10th Street, Suite A
Fairfield, IL 62837
Phone: 618-842-4617 Fax: 618-842-4743
www.fairfieldmemorial.org
AN AFFILIATE OF FAIRFIELD MEMORIAL HOSPITAL

Horizon Healthcare
An Affiliate of
Fairfield Memorial Hospital

PATIENT REGISTRATION FORM

213 NW 10th Street, Suite A
Fairfield, IL 62837
Ph 618-8424617
Fax 618-842-4743

Please present Driver's License & Insurance Cards for Copy

PATIENT INFORMATION:

Legal Name _____ Malden Name _____
(FIRST MIDDLE LAST)

Social Security Number _____ Date of Birth _____ Age: ____ ◯ Male ◯ Female

Address _____ City _____ St ____ Zip _____

◯ Home Phone _____ ◯ Cell Phone _____ ◯ Work Phone _____
(Please check your preferred phone)

Email Address: _____ *(we will not share this with other entities)*

Preferred Language:
__ English __Spanish __French __Chinese __Other

Ethnicity:
__Hispanic or Latino __Non-Hispanic or Latino

Religious Preference _____ (if none, please write N/A) Race: _____

Marital Status
__Single __Married __Domestic Partner __Life Partner __Divorced __Separated __Widow __Minor

Do you have any Advanced Directives: __Yes __No If 'Yes', please provide us with a copy of Advanced Directives.

Do you have any hearing or vision impairment: __No __Yes, hearing __Yes, vision Explain: _____

GUARANTOR INFORMATION: *(Complete this section if patient is a minor, or if someone other than patient is responsible for charges not paid by insurance)*

◯ Same as patient

Guarantor's name _____ Relationship to Patient _____

Guarantor's Phone #: _____ Guarantor's Date of Birth: _____ SS #: _____

Address: _____ City _____ St ____ Zip _____

◯ *Check here if address is same as patient*

EMERGENCY CONTACT FOR PATIENT:
Name: _____ Relationship: _____ Phone: _____

Secondary Contact/Support Role: Name _____ Relationship _____ Phone _____

IF PATIENT IS A MINOR, HAVE YOU COMPLETED A "WHEN YOU'RE NOT THERE" FORM? __YES __NO
If NO, please ask your customer service representative for a form.

Primary Insurance	Secondary Insurance
Insurance Company Name: _____	Insurance Company Name: _____
Policyholder's Name: _____	Policyholder's Name: _____
Policyholder's Date of Birth: _____ SS#: _____	Policyholder's Date of Birth: _____ SS#: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Employer: _____	Employer: _____
Relationship to Patient: _____	Relationship to Patient: _____
Effective Date of Coverage: _____	Effective Date of Coverage: _____
◯ *SAME AS PATIENT*	◯ *SAME AS PATIENT*
◯ *SAME AS GUARANTOR*	◯ *SAME AS GUARANTOR*

If any of the information above changes, please notify us in a timely manner. *If patient is unable to sign and you are Healthcare Power of Attorney or Legal Guardian, you must provide us with legal documentation for our records.* If applicable, please provide us with a copy of Advanced Directives as well.

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____ REV 9/2017

AUTHORIZATION TO VERBALLY RELEASE MEDICAL INFORMATION

There may be times when friends or family members, including spouses, may inquire about your healthcare, such as appointment times, prescription refills, test results, or general medical health information. This is *protected* information, and we cannot share that with anyone unless you have listed their name on this form. Please read carefully and let us know if your protected information can be released. If you prefer, you may note specifically what information can be released.

Please check one option below.

☐ I DO NOT want ANY of my information released, even to my spouse.

☐ I would like to name the following family member(s) or friend(s) as someone with whom Horizon Healthcare can share any of my information with, including psychiatric health, drug and alcohol treatment, and communicable diseases:

Name/Facility: _____ Relationship: _____

Name/Facility: _____ Relationship: _____

Name/Facility: _____ Relationship: _____

☐ I would like to name the following family member(s) or friend(s) as someone with whom Horizon Healthcare can share information regarding only the following medical condition(s):

_____

_____

Name/Facility: _____ Relationship: _____

If we needed to call you about health information or schedule changes, please specify whether or not we may leave a message on the following phones:

	Leave Message?		Phone Number
Home Phone:	Yes ☐	No ☐	_____
Cell Phone:	Yes ☐	No ☐	_____
Day Phone:	Yes ☐	No ☐	_____
Alternate Phone:	Yes ☐	No ☐	_____
Work Phone:	Yes ☐	No ☐	_____

I understand and acknowledge by signing below that it is my responsibility to notify Horizon Healthcare when any information changes, including but not limited to phone number, ability to leave a message, and those that may verbally have my information released to them.

Signature: _____ Date: _____
PATIENT, PARENT, OR LEGAL RESPONSIBLE PARTY

Relationship To Patient: _____

Patient's Date of Birth: _____

Witness: _____

REV 12-2016

FAIRFIELD MEMORIAL HOSPITAL ASSOCIATION

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 (FMH) and its physicians or independent contractors for all services, facilities, and supplies rendered.

In consideration of those hospital and medical services rendered by FMH, I hereby assign, transfer, and set over to FMH 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, subscriptions certificate, or other health benefit indemnification agreement otherwise payable to me for those services rendered by FMH.

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 telephone 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 monies due. This Assignment shall be binding upon all heirs, personal representatives, and successors. I further authorize FMH to apply any overpayment on any accounts to any other unpaid accounts that Ior 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 FMH is authorized to bill.

_____ Patient Signature — I, the undersigned, am the patient, and hereby consent to and accept the terms 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

_____

Signature of Patient or Legal Representative — Date

_____

Relationship to Patient

_____

Signature of Witness — Date

FAIRFIELD MEMORIAL HOSPITAL ASSOCIATION

CONSENT FOR MEDICAL TREATMENT

I request and authorize my physician and any other physicians consulted upon my behalf and Fairfield Memorial Hospital (FMH) 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 FMH to notify my referring physician, if any, of my addmission 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 goups: (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 providers 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).

MEDICARE INPATIENTS ONLY

I certify that the information given by my 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 uable 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.

_____

Signature of Patient or Legal Representative

_____

Relationship to Patient

_____ _____

Signature of Witness Date

Rev 08-2017

FAIRFIELD MEMORIAL HOSPITAL ASSOCIATION

ACKNOWLEDGEMENT OF LEGAL RELATIONSHIP

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

Christopher Ballard, MD
Wesley Thompson, MD
Marla Lafikes, MD
Nicole Fyie, MD
Kayla Bell, PA-C
John Snowden, PA-C
Heather Curtis APN FNP
Sherry Mewes, APN FNP
Renee Kohlman, APN, FNP
John Larrison, APN FNP
Dylan Wayne Stennett, APN FNP
Catherine Durbin, APN FNP
James Hopper, PA-C
Alexis King, CRNA
Kimberly King, CRNA
John Wall, CRNA
John Allen, CRNA
Gabriel Gigliotti, CRNA
Benjamin Curtis, CRNA
Thomas Falcone, CRNA
Jill Barnfield, LCSW
Nicole Uhlmann, LCSW

I acknowledge and understand that most 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 FMH are not employees or agents of FMH, 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 FMH 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, but are not limited to:

Rodney Beeler, MD
Douglas Frankel, MD
James Gruber, MD
Jasiri Kennedy, MD
Michelle O'Neill, MD
Scott Roustio, MD
Bruce Sobko, MD
Antonio Rodriguez, MD
Mark Murfin, MD
Steven Mitchell, MD
Justin Miller, MD
Clinical Radiologists
The Heart Group
Sridhar Bhaskara, MD
Jennifer Miller, DPM
Southern Illinois Surgical Care Associates
Premier Pathology Group, LLC
Gary Reagan, MD
Dwight Silvera, MD
Gibran Mahmud, MD
Sajjan Nemani, MD

I certify:

1. That I have read or have had this consent read to me;
2. That I was given an opportunity to ask questions; and
3. That all questions were answered to my satisfaction

_____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient

_____
Signature of Witness Date

FAIRFIELD MEMORIAL HOSPITAL ASSOCIATION

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Fairfield Memorial Hospital reserves the right to modify the privacy practices outlined in the notice. By signing below, I acknowledge that I have received a copy of the Privacy Notice for Fairfield Memorial Hospital.

Galbraith, Dennis
(Name of Patient)

_____
Signature of Patient or Patient Representative Date:_____

_____
Relationship to Patient

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

_____

_____
Signature of Staff

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

_____
Signature of Patient or Patient Representative Date

_____
Signature of Staff Date

To be retained for six years from date of signature

Patient Name: _____ Today's Date: _____

Patient Medical History

PLEASE PRESENT THIS COMPLETED FORM TO THE WINDOW IN SUITE A SO THAT IT CAN BE ROUTED TO YOUR NURSE PRIOR TO YOUR APPOINTMENT.

Patient Name: _____ Date of Birth: _____ Age: _____
Last First M.I.

Person completing form if patient is a minor: _____ Relationship: _____

Primary Pharmacy: _____ City of Pharm: _____

Secondary Pharmacy: _____ City of Pharm: _____

ALLERGIES: _____

Medical Diagnosis – Circle all that apply- Please include year of diagnosis, past and present:

Y / N Allergies _____
Y / N Anemia _____
Y / N Angina _____
Y / N Anxiety _____
Y / N Arthritis _____
Y / N Asthma _____
Y / N Atrial Fibrillation _____
Y / N Benign Prostate Hyperplasia _____
Y / N Blood clots _____
Y / N Cancer – Year Diagnosed _____
Type: _____
Y / N Cardiac Arrhythmia _____
Y / N COPD _____
Y / N Coronary Artery Disease _____
Y / N Depression _____
Y / N Diabetes – Year Diagnosed _____
Type: _____

Y / N Elevated Lipids _____
Y / N Gallbladder Disease _____
Y / N GERD _____
Y / N Headache/migraines _____
Y / N Heart Disease _____
Y / N Heart Valve Disease _____
Y / N Hepatitis/Liver Disease _____
Y / N Hypertension _____
Y / N Irritable Bowel Syndrome _____
Y / N Myocardial Infarction _____
Y / N Osteoporosis _____
Y / N Renal Disease _____
Y / N Seizure Disorder _____
Y / N Stroke _____
Y / N Thyroid Disease _____

Other / Explain: _____

Surgical History

Type of Surgery	Date of Surgery	Surgeon (if known)

If you have had more than five major surgeries, please attach list to this sheet. Thank you.

Last Mammogram: ___/___/___
Last Pap Smear: ___/___/___
Last Colonoscopy: ___/___/___

Tdap Vaccine: ___/___/___
Influenza Vaccine ___/___/___
Pneumococcal Vaccine: ___/___/___

Patient Name: _____ Today's Date: _____

Patient Medical History

Family History – (Disease process that could affect you, the patient)

Father - _____
Mother - _____
Sibling(s) - Brother: _____ Sister: _____
Child(ren) - Son: _____ Daughter _____
Maternal Grandmother - _____
Maternal Grandfather - _____
Paternal Grandmother - _____
Paternal Grandfather - _____

Social History

Do you use tobacco? Y N What type: _____
How much do you chew/smoke per day? _____
Are you a former Smoker? Y N Year you Quit: _____
How many years have/did you smoke/use tobacco? _____
Are you currently using any recreational drugs? Y N Name of Drug/s: _____
Are you a former drug-user? Y N Year you Quit: _____
How many years have/did you use drugs? _____
Do you drink alcohol? Y N How often/amount? _____
Type of alcohol (circle all that apply): Beer Wine Liquor
Do you consume caffeine on a daily basis? Y N Cups per day: _____
Marital Status: Single Married Divorced Separated Widowed
Occupation: _____

Advanced Directives

Living Will	Y	N	Power of Attorney (POA)	Y	N
Do Not Resuscitate (DNR)	Y	N	Name of POA: _____		
Healthcare Proxy	Y	N	Phone Number of POA: _____		
			Relationship of POA: _____		

PLEASE BRING A COPY OF YOUR ADVANCED DIRECTIVES/POA FORM TO YOUR APPOINTMENT.

Consulting Physicians

Please list any other providers you are currently seeing:

Name of Physician	Specialty	Phone Number
_____	_____	( )____-____
_____	_____	( )____-____
_____	_____	( )____-____
_____	_____	( )____-____
_____	_____	( )____-____

Patient Name: _____ Today's Date: _____

Patient Medical History

PEDIATRIC QUESTIONNAIRE

Who does patient live with? (Mother, Father, Stepparents, Grandparents, etc.)

_____

Names of all in household where patient lives	Relationship to Patient	Phone Number
_____	_____	( ) ____-____
_____	_____	( ) ____-____
_____	_____	( ) ____-____
_____	_____	( ) ____-____
_____	_____	( ) ____-____

Please list any child care the patient may have (nanny, sitter, day care, mother, father, etc): _____

_____

Are there Smokers at home? Y N Indoor or Outdoor Both

Grade in school _____ School Attending _____

PLEASE BRING A COPY OF YOUR CHILD'S IMMUNIZATION RECORDS TO YOUR APPOINTMENT.