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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

PATIENT REGISTRATION FORM

Please present Driver's License & Insurance Cards for Copy

PATIENT INFORMATION:

Legal Name _____ Maiden Name _____

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: _____ Ethnicity: _____
 English Spanish French Chinese Other 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: _____ |
| <input type="radio"/> SAME AS PATIENT | <input type="radio"/> SAME AS PATIENT |
| <input type="radio"/> SAME AS GUARANTOR | <input type="radio"/> 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: _____

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 <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Cell Phone: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Day Phone: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Alternate Phone: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Work Phone: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |

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: _____

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 for 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

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 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).

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

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
Carrie Nussmeyer, 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

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 MI.

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 Elevated Lipids _____ |
| Y / N Anemia _____ | Y / N Gallbladder Disease _____ |
| Y / N Angina _____ | Y / N GERD _____ |
| Y / N Anxiety _____ | Y / N Headache/migraines _____ |
| Y / N Arthritis _____ | Y / N Heart Disease _____ |
| Y / N Asthma _____ | Y / N Heart Valve Disease _____ |
| Y / N Atrial Fibrillation _____ | Y / N Hepatitis/Liver Disease _____ |
| Y / N Benign Prostate Hyperplasia _____ | Y / N Hypertension _____ |
| Y / N Blood clots _____ | Y / N Irritable Bowel Syndrome _____ |
| Y / N Cancer – Year Diagnosed _____ | Y / N Myocardial Infarction _____ |
| Type: _____ | Y / N Osteoporosis _____ |
| Y / N Cardiac Arrhythmia _____ | Y / N Renal Disease _____ |
| Y / N COPD _____ | Y / N Seizure Disorder _____ |
| Y / N Coronary Artery Disease _____ | Y / N Stroke _____ |
| Y / N Depression _____ | Y / N Thyroid Disease _____ |
| Y / N Diabetes – Year Diagnosed _____ | |
| Type: _____ | |

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: / /

Tdap Vaccine: / /

Last Pap Smear: / /

Influenza Vaccine / /

Last Colonoscopy: / /

Pneumococcal Vaccine: / /

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.