Patient Registration Form

Patient Name: _____
Last Name First Name Middle Initial

Address: _____
Street or Box City State Zip

Phone: (Primary) _____ (Cell) _____ (Work) _____

Date of Birth _____ Email: _____

Gender: ☐ Male ☐ Female SS#: _____

Marital Status: ☐ Single ☐ Married ☐ Widow/Widower ☐ Divorce

Employment Status: ☐ Full Time ☐ Part time Employer: _____

Student: ☐ Full Time ☐ Part time ☐ NA School: _____

Spouse Name: _____ DOB: _____ SS#_____

Race: ☐ American Indian or Alaskan Native ☐ White
☐ African-American ☐ Hispanic
☐ Asian ☐ Native Hawaiian
☐ Other:_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Language Spoken: _____

Drivers License#: _____ State: _____

Referred By: _____

Emergency Contact Name: _____Relationship:_____

Daytime Phone: _____Evening Phone: _____

Name of Preferred Local Pharmacy: _____Telephone:_____

Address: _____

Mail Order Pharmacy: _____

How did you hear about us: ☐ Newspaper Ad ☐ TV\Radio Ad ☐ Yellow pages
☐ Family/Friend Referral ☐ Internet ☐ Other_____

Reason for visit: _____

Primary Care Physician: _____ Telephone:_____

Please complete if PATIENT is a student or minor:

Mother's Name: _____ DOB: _____SS#: _____

Address: _____Phone:_____

Father's Name: _____ DOB: _____SS#: _____

Address: _____Phone:_____

Medical Information Form Date:_____

Patient Name:_____ DOB:_____

Medical History (Please include current and past medical issues)

Medical Issue	Date or Age	Please list any specialists who treated you

OB/GYN History

Date of last pap smear:_____
Have you ever had an abnormal pap? ☐ Yes ☐ No If yes, date and results_____
Date of last mammogram:_____
Have you ever had an abnormal mammogram? ☐ Yes ☐ No If yes, date and results_____
History of hysterectomy? ☐ Yes ☐ No If yes, date and why?_____
Do you have an OB/GYN? ☐ Yes ☐ No If yes, then who?_____
Age of first period:_____ Date of last period:_____
Pregnancies: Total #___ Full Term___ Miscarriages___ Abortions___ Premature___ Tubal___
Complications:_____

Surgical History

Date or Age	Surgery

Hospitalizations

Date or Age	Reason/Details

Family History (place a checkmark where applicable)

	Alive (A) Deceased (D)	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness (Type?)	Cancer (Type?)	Unknown	Other
Father									
Mother									
Sibling(s)									
Son(s)									
Daughter(s)									
Paternal Grandfather									
Paternal Grandmother									
Maternal Grandfather									
Maternal Grandmother									
Paternal Uncle									
Paternal Aunt									
Maternal Uncle									
Maternal Aunt									

Other (please explain)_____

Social History

Are you a current smoker? ☐ Yes ☐ No If no, then have you ever smoked? ☐ Yes ☐ No
How many per day?_____ For how many years?_____
What year did you quit?_____ Are you interested in quitting? ☐ Yes ☐ No
Do you use other tobacco products, and if so, what?_____ _____

Do you drink alcohol? ☐ Yes ☐ No How many drinks per day?____ How many times a week?_____
Do you use any recreational drugs, and if so, what?_____
Have you ever had an alcohol or drug problem in the past? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No ☐ Single Partner ☐ Multiple Partners
Any history of sexually transmitted infections, and if so, what?_____

Do you drink caffeine? ☐ Yes ☐ No How much per day?_____

Occupation:_____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have children? ☐ Yes ☐ No What are their ages?_____

Additional Information

Any other family members attend our clinics, and if so, who?_____

Who was your prior primary care physician and location? When was your last visit?
_____

What would you like to discuss with the physician today?
_____
_____
_____

Current Medications **(prescription, over-the-counter, vitamins, supplements, or herbals)**

Medication Name	Dosage	How often?
Example: Name of drug	5 mg	One pill twice a day or one pill daily

Allergies **(medications, x-ray dyes, other substances, seasonal, etc.)**

Name of Substance	Reaction
Example: Name of drug	Hives, swelling

Health Maintenance/Screening/Special Tests **(list the dates of your last studies/exams)**

Study/Exam	Approximate Date/Year	Abnormal?
Physical/Annual exam		
Bone density test		
Colonoscopy		
EKG		
Stress test		
PSA (Prostate-specific antigen)		
Dental exam		
Eye exam		

Immunizations **(list the dates when you received the vaccines)**

Immunization	Approximate Date/Year
Flu	
Pneumonia	
Tetanus	
Tdap (tetanus plus whooping cough)	
Hepatitis B	
Gardasil	
Tuberculosis screening ☐ Pos ☐ Neg	
Shingles	

Would you be interested in receiving these today? ☐ Yes ☐ No

Review of Systems (Circle the items that you are CURRENTLY experiencing)

General
Fever
Chills
Night sweats
Weight loss
Weight gain
Fatigue

Eyes
Vision changes
Eye redness
Eye drainage
Eye pain
Corrective lens

Ear, Nose, & Throat
Hearing changes
Ear pain
Ear drainage
Nasal congestion
Runny nose
Postnasal discharge
Nose bleeds
Sore throat
Voice changes

Cardiovascular
Chest pain
Palpitations/heart racing
Shortness of breath
Shortness of breath when lying flat
Swelling in the legs/feet
Leg/foot pain
Varicose veins

Pulmonary
Shortness of breath at rest
Shortness of breath with walking
Cough
Wheezing
Snoring

Gastrointestinal
Abdominal pain
Nausea
Vomiting
Heartburn/indigestion
Difficulty/pain with swallowing
Change in bowel movements
Diarrhea
Constipation
Blood in the stool

Male Genitourinary
Pain with urination
Frequent urination
Urgent need to urinate
Abnormal urine stream
Urinary incontinence
Blood in the urine
Erection problems
Discharge from the penis

Female Genitourinary
Pain with urination
Frequent urination
Urgent need to urinate
Urinary incontinence
Blood in the urine
Vaginal discharge
Pelvic pain
Painful periods
Irregular periods

Musculoskeletal
Neck pain
Back pain
Joint pain
Muscle pain

Integumentary
Rash
Itching
Dry/sensitive skin
Breast masses/lumps
Nipple discharge

Neurological
Headache
Dizziness
Numbness
Weakness
Tingling
Memory loss

Psychiatric
Depression
Anxiety
Mania/euphoria
Mood swings
Hallucinations

Endocrine
Excessive urination
Excessive thirst/drinking
Excessive hunger
Feeling cold all the time
Feeling hot all the time

Hematology/Lymph
Swollen lymph nodes
Excessive bruising
Excessive bleeding
Anemia
History of transfusion

Allergy/Immunology
Lip/facial swelling
Hives
Environmental allergies
Seasonal allergies
Food allergies

St. Joseph Physician Associates

Medical Record Release Form

Name:_____ DOB:_____ SS:_____

Address:_____ Phone:_____

From/To (*please circle intended direction)*

Name:	Phone ( )	Fax ( )
Address:		

From/To (*please circle intended direction*)

Name:	Phone ( )	Fax ( )
Address:		

Purpose of Disclosure:

☐ Continuity of Care	☐ Insurance	☐ Legal	☐ Personal Use
☐ Transfer of Care	☐ Other (please specify):		

Records to include:

This authorization pertains to the disclosure of record types indicated below between following dates of service: From:_____ To:_____ OR ☐ All records retained by this facility

☐ Progress Notes	☐ Lab Notes	☐ Immunization Records	☐ Operative Reports
☐ Hospital Records	☐ Imaging Records	☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____***Initials***

Expiration: This authorization shall expire 180 Days from date of signature.
I understand that this authorization may be revoked by me at anytime except to the extent that action has been taken. I have the right to revoke this Authorization at any time prior to 180 days by giving the healthcare provider written notice of revocation of this Authorization. _____***Initials***

Re-disclosure: I understand the information disclosed by this Authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996.

I understand that:

- I have the right to refuse to sign this Authorization
- I have the right to receive a copy of this Authorization
- I have the right to inspect or copy the protected health information to be used or disclosed
- Fees/charges will comply with all laws and regulation applicable to release of information

I have read the above and authorize the disclosure of the protected health information as stated.

_____	_____	_____
Date	Signature of Patient/Parent/Guardian	Relationship to patient

Consent for Admission and Registration

St. Joseph Regional Health Center - Bryan, Texas

St. Joseph

1. Legal Relationship between Facility and Physician

I understand that I am seeking care at a St. Joseph Health System facility (hereinafter referred to as the or this facility) and give my consent to my attending practitioner or his/her designees, including other practitioners, facility personnel, and students to perform or administer all treatments, radiology examinations, medical diagnostic tests, anesthesia and facility care, which in the judgment of such practitioners, are advisable during the course of my diagnosis and treatment. Some practitioners furnishing services to patients, including, but not limited to anesthesiologists, radiologists, pathologists, and emergency room physicians are independent contractors who may be selected by me and are not employees or agents of the facility. I understand that I will be billed separately for their professional services and all questions relating to their services should be directed to them. I understand that within some Facility settings, Facility will bill for services provided by a provider who is a direct employee of or otherwise contracted with the Facility.

2. Consent to Medical and Surgical Procedures

I understand and give consent to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment, or services and which may include, but are not limited to, laboratory procedures, x-ray examination, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or Facility services rendered to me under the general and special instructions of my physician. St. Joseph Regional Health Center is a teaching Facility. It is affiliated with Medical Schools, Nursing Schools, and other academic programs. I agree to allow resident physicians, nursing interns, and health care students to be involved in my care.

Exposure notice: I understand that Texas law provides that if any healthcare worker is exposed to my blood or other bodily fluid, my blood or other bodily fluid will be tested by this facility to determine the presence of any communicable disease, including but not limited to Hepatitis, Human Immunodeficiency Virus (which is the causative agent of AIDS), and Syphilis. I understand such testing is necessary to protect those will be caring for me while I am a patient of this Facility. I understand that the results of the tests taken under these circumstances do not become part of my medical record.

Medical Screening Examination (MSE): The facility will provide an MSE as required to all patients who are seeking emergent medical services to determine if there is an emergency medical condition, without regard to the patient's ability to pay. If there is an emergency medical condition, the facility will provide stabilizing treatment within its capacity. However, patients who do not qualify under the facility's charity care policy or other applicable policies are not relieved of their obligation to pay for these services.

3. Assignment of Benefits, Authorizations, and Irrevocable Assignments

This assignment of benefits allows the Facility and/or Facility based physicians to be paid directly by my health insurance carrier or other health benefit plan for the services the Facility and/or Facility based physicians provide to me, my minor child, or other person entitled to health care benefits for this admission. In return for the services rendered and to be rendered by the Facility and/or Facility based physicians, I hereby irrevocably assign and transfer to the Facility and/or Facility based physicians all right, title, and interest in all benefits payable for the health care rendered, which are provided in any and all insurance policies and health benefit plans from which my dependents or I are entitled to recover. This assignment and transfer shall be for the purpose of granting the Facility and/or Facility based physicians an independent right of recovery against my insurer or health benefit plan, but shall not be construed as an obligation of the Facility and/or Facility based physicians to pursue any such right of recovery. I understand that any payment received from these policies and/or plans will be applied to the amount that I have agreed to pay for services rendered during this admission as further described in the Financial Agreement section. If precertification/authorization is required and is not obtained by my practitioner or myself, I understand that I may be responsible for any penalties that may be enforced by my insurance carrier unless the facility has a contract with my HMO/PPO to provide precertification. The above facility will make a reasonable effort to obtain authorization and/or precertification on every case. However, I understand that I may be responsible for any charges that are not covered by my insurance carrier for any reasons, inclusive of any days that my insurance carrier does not allow during my stay within the Facility for which my insurance carrier will not pay.

4. Financial Agreement

In consideration of the services rendered to the patient, the undersigned (as parent, guardian, spouse, guarantor, agent or as the patient) individually promises to pay the patient account at the rates stated in the Facility's price list (known as the "Charge Master") effective on the date the charge is processed for the services provided, which rates are hereby expressly incorporated by reference as the price of this Agreement to pay the patients account. An estimate of the anticipated charges for services to be provided to the patient is available upon request from the Facility. Estimates may vary significantly from the final charges based on a variety of factors, including but not limited to the course of treatment, intensity of physicians practices, and the necessity of providing additional supplies and services.

If supplies and services are provided to me and I have coverage through a governmental program or through certain private health insurance plans, the facility may accept a discounted payment for those supplies and services. In this event any payment required from me will be determined by the terms of the governmental program or private health insurance plan. If I am uninsured and not covered by a governmental program, I may be eligible to have my account discounted or forgiven under the facility's uninsured discount or charity care programs in effect at the time of treatment. I may request information about these programs from the facility. As a courtesy to me, the facility may bill my insurance company, but is not obligated to do so. Regardless, I agree that except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. If the hospitalization lasts longer than thirty days, the facility may bill for services every thirty days and payment is immediately due. However, immediate payment may be waived at the sole discretion of the Facility upon the assignment of adequate insurance benefits. I further acknowledge and agree that if payment in full is not made within 30 days of it being due, any unpaid balance may be referred to the facility's collection agent.

I understand that any overpayment made by my insurance company(s) will be investigated by the facility. Overpayments may be applied by the Facility to any unpaid Facility accounts for which I am listed as guarantor. Any refund will be made to the proper party, as stipulated in my insurance contract. I agree to pay any services that are not covered by my insurance company. This includes, but is not limited to, coinsurance, deductibles, non-covered benefits due to policy limits or policy exclusions as well as failure to comply with my insurance plan requirements. In the event that the Facility has to engage an attorney or collection agency to collect any unpaid balances that arise from the treatment consented to herein, the undersigned agrees to pay the reasonable attorney's fees and collection expenses incurred by the Facility.

5. Release of Photography
Unless directed otherwise, I agree to allow photographs to be taken of the operation or procedure to be performed, including appropriate portions of my body, for medical, scientific and educational purposes.

6. Medicare Patient Certification and Assignment of Benefit
I certify that the information I provide in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the Hospital or hospital-based physician by the Medicare or Medicaid program.

7. Notice of Privacy Practices
I acknowledge that within the past year, I have received, and signed, a copy of the Notice of Privacy Practices of the St. Joseph Health System. Otherwise, a facility team member will request I complete a new notice. I understand the notice of privacy describes the ways in which the facility may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I have the right to review the notice prior to signing this consent and to request a copy of this notice.

8. Medical Record Management and Retention
I understand my medical records may be destroyed ten (10) years after I was last treated in the facility or, if I was younger than eighteen (18) years of age when I was last treated at the facility, on my 20th birthday or ten (10) years after the date I was last treated, whichever date is later.

9. Personal Valuables
I understand that the Facility maintains a safe for the safekeeping of money and valuables, and the Facility shall not be held liable for the loss or damage to any money, jewelry, documents, dentures, hearing aids, eyeglasses, or other articles of unusual value and small size, unless placed therein, and shall not be liable for loss or damage to any other personal property, unless deposited with the Facility for safekeeping.

10. Weapons/Explosives & Drugs
I understand and agree that if the Facility at any time believes there may be a weapon, explosive device, illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the Facility may search my room and my belongings, confiscate any of the above items that are found, and dispose of them as appropriate, including delivery of any item to law enforcement authorities.

11. Patient Rights
I acknowledge that I have been given information and instructions regarding my Patient Rights. My Patient Rights include, but are not limited to, the right to make medical decisions, including the right to accept or refuse medical treatment, participate in my plan of care and receive care in a safe setting, free from verbal or physical abuse or harassment. I also understand that if I have questions regarding my rights, I should ask an employee of this facility for assistance. **Patient's Bill of Rights:**

I, as the patient, have a right to:

- receive reasonable access to care and treatment that is medically indicated as necessary and within the facility's capability and mission, regardless of race, creed, sex, age, national origin, or sources of payment for care;
- receive considerate, respectful care at all times and under all circumstances, with recognition of personal dignity;
- be free from all forms of abuse or harassment;
- be free from restraints and seclusion in any form when used as a means of coercion, discipline, convenience for the staff, or retaliation;
- personal and informational privacy, within the scope of the law;
- expect that a family member or representative of my choice and my own physician will be notified promptly of my admission to the facility;
- the presence of a support individual of my choice, unless the individual's presence infringes on others' rights, safety, or is medically or therapeutically contraindicated;
- designate visitors subject to limitations that are clinically necessary;
- expect reasonable safety insofar as the facility practices and environment are concerned and request additional assistance when I have a concern about my condition;
- know the identity and professional status of individuals providing service;
- obtain, from the practitioner responsible for coordinating care, complete and current information concerning diagnosis (to the degree known), treatment, and any known prognosis;
- means of communication with people outside the facility by means of visitors and by oral and written communication in my preferred language for discussing healthcare, and by access to an interpreter if language barriers exist;
- reasonably informed participation in decisions involving health care and receive information about experiments, research, or educational projects affecting my care and treatment; the patient has the right to refuse to participate in any such activity.
- consult with a specialist at my own request and expense;
- accept or refuse medical care to the extent permitted by law;
- receive an explanation if being transferred to another facility;
- request and receive an itemized and detailed explanation of my total bill for services when available;
- be informed of facility rules and regulations applicable to my conduct as a patient;
- participate in the consideration of ethical issues that arise during my care;
- formulate advance directives and appoint a surrogate to make health care decisions on my behalf as described above;
- receive appropriate assessment and effective management of pain.

I have the responsibility to:

- provide accurate and complete health information and to understand my plan of care;
- follow the plan of care developed by me and my healthcare team;
- accept responsibility for the outcomes of refusing treatment or for not following my agreed upon plan of care;
- fulfill my financial obligations;
- be considerate of the rights of others and follow the rules and regulations of this facility about patient care and conduct.

St. Joseph Health System
Provider Practices
Insurance Network Information Notice

Dear Patient/Responsible Party:

State law requires health care providers to notify consumers of the insurance networks that they participate in. This St. Joseph Health System facility participates in,(but is not limited to), the following insurance networks:

Aetna (including TRS ActiveCare) PPO, POS	Integrated Health Plan
Amerigroup CHIP, Managed Medicaid: STAR, STAR Plus	Integrated Medical Systems
Blue Cross Blue Shield PPO/Traditional	Molina CHIP, Foster Care, Perinatal *(utilizing Texas True Choice)*
Beech Street PPO	Multiplan
Blue Bell (*currently utilizing PHCS)*	PHCS
Cigna (including Great West/GWH-Cigna) PPO, **HMO	Provider Select, Inc. PPO
Cigna Local Plus/ St. Joseph Employee Health Plan	Superior CHIP, Foster Care, Perinatal, Managed Medicaid: STAR, STAR Plus
Coventry/First Health PPO	TRICARE Standard, Prime Remote
FirstCare PPO, **HMO	Texas True Choice
Galaxy Health Network PPO	Three Rivers Provider Network PPO
HealthSmart Preferred Care PPO	USA MCO PPO
Humana ChoiceCare PPO, POS, EPO, **HMO	United Healthcare (excluding Medicare Advantage plans & Managed Medicaid; Community Plan)

**HMO network participation only applies to those plans offered in our local coverage area. HMO/Limited Network plans offered by employers in surrounding cities may not be included in our local coverage area and would require prior authorization.

All St. Joseph Health System facilities are providers for traditional *Medicare and TMHP-Medicaid plans. *(*Medicare Part B for Provider Practices)*

Medicare Replacements

Humana Medicare Advantage PFFS, PPO	*St. Joseph is not contracted with Care Improvement Plus; however, it is our understanding that there is not an in-network versus out-of-network differential in patient benefits.
Aetna Medicare Advantage	
Care Improvement Plus*	

Workers Compensation

Beech Street CORVEL Multiplan Providence Rockport Texas Healthcare Foundation	Public Subdivision Workers' Compensation Alliance (PSWCA): -Texas Association of Counties Risk Management Pool -Texas Association of School Boards Risk Management Fund -Texas Municipal League Intergovernmental Risk Pool -Texas Council Risk Management Fund -Texas Water Conservation Association Risk Management Fund	Coventry: *(client specific)* -Texas Star Network (Texas Mutual Insurance) -Liberty Mutual Health Care Network -First Health / Constitution State Services LLC HCN -First Health / Travelers HCN -First Health / AIGCS TX HCN -Zenith Health Care Network

If you have questions regarding a bill from a St. Joseph Health System facility, please contact the appropriate Patient Financial Services department listed below; available Monday-Friday, 8am to 5pm.

- For Provider Billing: (979) 731-5250.
- For Hospital Billing: (979) 776-3952

In addition to services provided by this St. Joseph Health System facility, other caregivers may participate in caring for you or your family member. The caregivers listed below are not employees of this facility. They bill separately for the services they provide and they may not necessarily participate in the same insurance networks as the St. Joseph Health System facility.

If you have questions for one of these caregivers, please contact their office(s) directly for assistance, at the numbers listed below:

Radiologists:	*Anesthesiologists:*	*Pathologists:*	*Hospitalists:*
Bryan Radiology Associates (979) 776-8291	American Anesthesiology of Texas, Inc. (979) 776-4777	Brazos Valley Pathology (979) 774-5478 Toll free: (866) 414-0071	Sound (877) 636-7852

Above all – Thank you for choosing this St. Joseph Health System facility for your and your family's needs.

Sincerely –

St. Joseph Health System