Ozarks Community Hospital

Patient Information- Please fill out form **completely**. Account #:_____

Name: _____ **Maiden name:**_____ **Date:** ___/___/_____
Last First MI

Address: _____
PO Box/ Street City State Zip Code COUNTY

Home #: _____ **Wk:** _____ **Cell:** _____

Employer:_____ **Address:**_____
PO Box/ Street City State Zip Code

Sex: M F **Marital Status:** M S W D **DOB:** ___/___/_____ **SSN:** _____-_____-_____

Email Address: _____(for internal use only) **Smoke? Y N**

Referring Physician: _____ **Primary Care Physician:** _____

What state where you born in? _____ **Religious Preference:** _____ **Race** _____

Chief Complaint:_____ **Accident? Y N Accident Date:**___/___/_____ **Time:** _____

Brief Description of Accident:_____ **Surgery? Y N Surgery Date:** ___/___/_____

Emergency Contact:

Name: _____ **Relationship:**_____ **DOB:**_____ **Ph:**_____

Spouse or Responsible Party (if minor):

Name: _____ **DOB:**___/___/_____ **SSN:**_____-_____-_____

Address:_____
PO Box/Street City State Zip Code COUNTY

Relationship to the patient:_____ **Ph:** _____ **Wk:**_____x_____

Employer:_____ **Address:**_____
PO Box/ Street City State Zip Code

Insured's Information: (Write "same" if the insured is the same as the patient.)

Primary Insurance Company: _____ **Name of Policy Holder:**_____
Address:_____
PO Box/ Street City State Zip Code COUNTY
DOB: ___/___/_____ **SSN:** _____-_____-_____ **State Born In:** _____ **Relationship:**_____

Secondary Insurance Company: _____ **Name of Policy Holder:**_____
Address:_____
PO Box/ Street City State Zip Code COUNTY
DOB: ___/___/_____ **SSN:** _____-_____-_____ **State Born In:** _____ **Relationship:**_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I verify that all information above is correct to the best of my knowledge.
I authorize OCH to release any of my medical information necessary to process claims. I allow a copy of this authorization to be used in place of the original.

_____ ___/___/_____
Patient/ Guardian Signature **Date**

Rev. 2/26/2010

Ozarks
Community Hospital

GENERAL MEDICAL INFORMATION

Current medical problems/reason for today's visit: _____
Current medications: _____
Allergies to medication: _____
Allergies (other than medications) Example: laundry detergent, latex, etc: _____
_____
Other physicians or nurse practitioners currently treating you: _____
_____
Previous medical problems or other medical problems: _____
_____
List any previous surgery or hospitalizations (please include miscarriages and life births): _____
_____
_____
Females only: Are you pregnant? Yes No Planning a pregnancy? Yes No Nursing a child? Yes No
Do you smoke? Yes No **If yes, circle one** Cigarettes Pipe Cigar Number of years: _____ How much per day? _____
Do you regularly drink alcohol? Yes No **If yes, please indicate how much per day:** _____
Do you regularly drink coffee? Yes No **If yes, please indicate how much per day:** _____
Are you under a lot of pressure at work or home? Yes No **If yes, please describe:** _____
_____
_____

GENERAL MEDICAL INFORMATION
Have you ever had any of the following? Please check all that apply.

_____ Chest Pain	_____ Asthma	_____ TB/Lung Disorders
_____ Chest Pressure / Tightening	_____ Dizzy Spells	_____ Ulcers
_____ Hypertension	_____ Cancer	_____ Skin Disorders
_____ Heart Attack	_____ Diabetes	_____ Hepatitis
_____ Stroke	_____ Arthritis	_____ Cataracts
_____ Headaches	_____ Difficulty Hearing	_____ Digestive Problems
_____ Glaucoma	_____ Memory Loss	_____ Frequent Urinary Infections
_____ Allergies or Eczema	_____ Hemorrhoids	_____ Abnormal Pap Smear (if female)
_____ Depression	_____ Kidney Disease	_____ Other _____
_____ Blood in Stool	_____ Shortness of Breath	

IMMUNIZATIONS
Last year received, if known

SMALL POX _____
TETANUS _____
TYPHOID _____
POLIO _____
INFLUENZA _____
PNEUMONIA _____
RUBELLA _____
HEPATITIS _____
OTHER _____

FAMILY HISTORY
List any relatives that have/had the following

HIGH BLOOD PRESSURE _____
EPILEPSY _____
ECZEMA PSORIASIS _____
HEART ATTACK _____
STROKE _____
DIABETES _____
ASTHMA _____
HAY FEVER _____
CANCER _____
OSTEOPOROSIS _____

OZARKS COMMUNITY HOSPITAL

Communication Preferences

Patient Name: _____
Please Print

You may _____ may not _____ contact me for appointment reminders.

You may _____ may not _____ leave the message on my answering machine. The number you may use is: _____.

If I am not home, you may leave the message with the following individual(s):

_____

_____

_____

You may discuss my medical information with: _____

_____

_____

_____

Signature: _____ Date: _____

Witnessed: _____ Date: _____

Revised 10/22/2009

CONDITIONS OF ADMISSION

I wish to be admitted to Ozarks Community Hospital (OCH) for inpatient or outpatient services. I understand services are available to me without discrimination prohibited by federal and state law. I understand that healthcare and related services will be provided by employees, agents and independent contractors utilized by OCH.

Consent. While in the hospital, I understand that my care and treatment are under the control of my physician, and I hereby consent to such care and treatment, including but not limited to diagnostic, medical, therapeutic testing and treatment as may be deemed necessary or advisable by my physician. I hereby allow OCH to process and dispose, as required by federal and state law and regulation, any specimen of mine taken for laboratory or pathology examination or removed by surgery. I understand I have the right to limit or refuse recommended treatments and/or procedures. I further consent to X-ray, photographic and video recordings for diagnostic or therapeutic purposes. I agree that this consent will remain effective through my discharge and for a period of 90 days in the case of recurring services. I give this consent while acknowledging that no guarantees have been made to me concerning the outcome of my care and treatment.

Advanced Healthcare Directive. I acknowledge that I have been provided with information regarding patient rights and the patient's right to prepare an advanced healthcare directive.

Use and Disclosure of Information. I acknowledge receipt of the document, "NOTICE OF PRIVACY PRACTICES." I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that OCH may use and disclose this information: to conduct and plan my treatment; to obtain payment; and to conduct normal healthcare operations.

Financial Authorization. In consideration of services rendered, supplies furnished and credit extended, I hereby authorize payment of all benefits applicable to my care and treatment to be made directly to OCH and all contracted physicians, and I appoint OCH power-of-attorney in the collection of such benefits. I acknowledge that I am responsible for completion of any insurance pre-certification requirement and that, though OCH assists with the pre-certification process, it does not thereby assume responsibility for pre-certification. I understand that my physician may order tests or treatments not included in the hospital charge and that I will be billed separately for those items or services. I understand that I am responsible for all charges not collected by OCH from the third-party payers of such benefits. In the event OCH does not receive payment in full, I agree to pay all costs of collection, including a reasonable attorney fee. **If I am signing and I am not the patient, I understand that I shall be personally responsible for all such charges and costs. I understand and agree that OCH is not responsible for loss or damage to my personal property.**

Medicare Patients. I hereby affirm that information provided by me to obtain Medicare benefits is correct. I have responded to the "Medicare Secondary Payer Screening." I authorize assignment of benefits to OCH.
Medicare/Tricare/Champus Inpatient. I acknowledge receipt of the document, "An Important Message from Medicare/Tricare/Champus."

Physician Ownership. OCH is owned by physicians who practice at the hospital and its clinics. I understand that I have the right to obtain a list of the names of the physician owners.

Patient/Parent	Date	Witness	Date
Guarantor/Guardian	Date	Place Patient Label Here	

Revised 1/27/2010

Ozarks Community Hospital
PATIENT CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

I understand that I have certain rights to privacy regarding my protected health information. I have been given the right to review your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that you have the right to change your Notice of Privacy Practices from time to time.

I consent that this information can be used by Ozarks Community Hospital to:

- conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment, directly or indirectly;
- obtain payment from third-party payers; and
- conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that as a part of such treatment, payment or healthcare operations, it may be necessary for the hospital to disclose my protected health information to other persons or entities, and I consent to such disclosure for those purposes.

I understand that I may ask the hospital to restrict how my private information is used or disclosed. If I ask the hospital to restrict how my private health information is used or disclosed in conducting treatment, payment, or healthcare operation, I understand that the hospital is not required to agree to my requested restriction.

I understand that I may revoke this consent in writing at any time, except to the extent that the hospital has taken action relying on this consent. I understand that by refusing to sign this consent or by revoking this consent the hospital may refuse to treat me.

Patient Name (print): _____

Signature: _____ Date: _____

Relationship to Patient: _____

RESTRICTION ON DISCLOSURE OF DIRECTORY INFORMATION

It is the policy of this hospital to maintain a directory of patients being treated in this facility. The information in the directory would include your name, your location in the facility, and your general condition without reference to specific medical condition (for example: "stable", "fair", "critical", etc.). You should know that directory information will be provided to anyone who asks for it and asks about you by name. The hospital will agree to exclude you from this directory upon your written request. Please understand that the hospital cannot agree to a partial disclosure of directory information only to specified individuals (such as family or friends).

If you object to disclosure of this information and do NOT want to be included in the directory, please sign below.

Signature: _____ Date: _____

Revised 1/27/2010

Patient Satisfaction Survey

Thank you for choosing Ozarks Community Hospital
We are interested in knowing how your visit went.

INSTRUCTIONS: Please rate the services you received at Ozarks Community Hospital. Circle the number that best represents your feelings. If you did not receive a service, skip to the next question. Space is provided for your comments. When you have completed the survey, please insert into one of the survey collection boxes located throughout the hospital or give to a staff person.

General Surgery Questions (fill in the box)

1. Date of your visit: Month _____ Day _____ Year _____
2. Time of day you arrived? (select one) [ ] 7 AM – 7 PM [ ] 7 PM – 7 AM
3. What service did you receive?

[ ] Inpatient Care [ ] Office Visit [ ] Emergency/ Urgent Care [ ] Outpatient Testing

4. How long did you wait before you were seen? Hours _____ Minutes _____
5. What doctor or provider did you see? _____

Admissions and Registration	**Very Poor**	**Poor**	**Fair**	**Good**	**Very Good**
1. Speed of the admissions/registration process	1	2	3	4	5
2. Courtesy of admissions/registration personnel	1	2	3	4	5
3. Helpfulness of the staff	1	2	3	4	5
4. How satisfactory was the triage/admissions process	1	2	3	4	5
5. Privacy you felt during the registration/admissions interview	1	2	3	4	5

Comments _____

Social Services	**Very Poor**	**Poor**	**Fair**	**Good**	**Very Good**
1. Social Worker responded in timely manner to needs	1	2	3	4	5
2. Concerns were adequately addressed and information requested was provided (nursing home, advance directive, etc.)	1	2	3	4	5

Comments _____

Nurses	**Very Poor**	**Poor**	**Fair**	**Good**	**Very Good**
1. Courtesy and friendliness of the nurses	1	2	3	4	5
2. Nurses attitude toward your care.	1	2	3	4	5
3. Responding quickly to the call lights (Inpatient care only)	1	2	3	4	5
4. Nurses kept you informed about your treatment	1	2	3	4	5
5. Evaluate overall nursing care received on the following shifts					
A. Day Shift	1	2	3	4	5
B. Night Shift	1	2	3	4	5
6. Nurses' concern for your privacy	1	2	3	4	5

Comments _____

Doctors	**Very Poor**	**Poor**	**Fair**	**Good**	**Very Good**
1. Waiting time before you were seen by doctor	1	2	3	4	5
2. Courtesy of the doctor	1	2	3	4	5
3. Level that doctor took your problem seriously	1	2	3	4	5
4. Doctor's concern for your comfort during treatment	1	2	3	4	5
5. Doctor explained your tests and treatment	1	2	3	4	5

Comments _____

Your Room # _____ (if inpatient)	**Very Poor**	**Poor**	**Fair**	**Good**	**Very Good**
1. Pleasantness of room décor	1	2	3	4	5
2. Room temperature	1	2	3	4	5
3. Noise level in and around room	1	2	3	4	5
4. Working order of items in room (TV, call light, etc.)	1	2	3	4	5
5. Courtesy from person cleaning your room	1	2	3	4	5
6. How well your room is cleaned	1	2	3	4	5

Comments _____

Diet and Meals	Very Poor	Poor	Fair	Good	Very Good
1. Explanations you were given about diet if needed	1	2	3	4	5
2. Temperature of the food (cold foods cold, hot foods hot)	1	2	3	4	5
3. Quality of the food	1	2	3	4	5
4. Variety of menu	1	2	3	4	5

Comments _____

Lab Tests	Very Poor	Poor	Fair	Good	Very Good
1. How well your blood was taken (quickly, little pain, etc.)	1	2	3	4	5
2. Courtesy of the person who took your blood	1	2	3	4	5
3. Verified name before taking blood	1	2	3	4	5

Comments _____

Imaging Department	Very Poor	Poor	Fair	Good	Very Good
1. Waiting time in the department	1	2	3	4	5
2. Courtesy of the Technologist	1	2	3	4	5
3. Technologist's concerns for your comfort	1	2	3	4	5
4. Professionalism of the Technologist	1	2	3	4	5
5. Technologist explanation of procedure	1	2	3	4	5

Comments _____

Cardio Pulmonary	Very Poor	Poor	Fair	Good	Very Good
1. Waiting time before procedure	1	2	3	4	5
2. Courtesy and professionalism of staff	1	2	3	4	5
3. Explanation of tests and treatment	1	2	3	4	5

Comments _____

Surgery	Very Poor	Poor	Fair	Good	Very Good
1. Preparation for your visit	1	2	3	4	5
2. Promptness of the staff	1	2	3	4	5
3. You were adequately informed about procedures and treatment	1	2	3	4	5

Comments _____

Physical Therapy	Very Poor	Poor	Fair	Good	Very Good
1. Would you recommend our physical therapy department to others	1	2	3	4	5
2. Courtesy and professionalism of physical therapy staff	1	2	3	4	5
3. Waiting time before being seen for therapy	1	2	3	4	5

Comments _____

Family/ Friends Accommodations	Very Poor	Poor	Fair	Good	Very Good
1. Courtesy with which family or friends were treated	1	2	3	4	5
2. Staff concern to keep family/ friends informed about	1	2	3	4	5
your treatment or condition	1	2	3	4	5

Comments _____

Discharge and Final Ratings	Very Poor	Poor	Fair	Good	Very Good
1. How well you were kept informed about delays you	1	2	3	4	5
may have experienced during your treatment	1	2	3	4	5
2. Level at which staff cared about you as a person	1	2	3	4	5
3. Likelihood of your recommending our hospital to others	1	2	3	4	5
4. Advice you were given about caring for yourself at home	1	2	3	4	5
5. Adequacy of signs and directions in the hospital	1	2	3	4	5

Comments _____

Would you like to commend a staff member(s) who did an especially good job while you were at Ozarks Community Hospital?

_____

_____