

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)

Referring Physician: _____ Primary Care Physician: _____

What state where you born in? _____ Smoke? Y N Religious Preference: _____

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



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 live births): _____

Females only: Are you pregnant? yes no planning a pregnancy? yes no nursing a child? yes no Last Menstrual Period? _____

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, If female (abnormal pap smear), 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, STROKES, DIABETES, ASTHMA, HAYFEVER, OSTEOPOROSIS, OTHER

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: _____

Ozarks Community Hospital – Carthage

Communication Preferences

Patient name: _____
(printed)

My medical information may be discussed with:

Name	Phone Number	Relationship

You may _____ may not _____ contact me for follow-up calls and/or appointment reminders.

You may _____ may not _____ leave messages 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): _____

Signature: _____ Date: _____

Witness: _____ Date: _____

CONDITIONS OF ADMISSION

I wish to be admitted to Ozarks Community Hospital (OCH) for inpatient or outpatient services.

Consent. I understand that my care is under the control of my physician, and I hereby consent to such care including but not limited to diagnostic tests (which may include HIV testing) and medical treatment deemed necessary 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.

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.**

I acknowledge receipt of the following described documents and information:

Patient Rights and Advanced Healthcare Directive. I acknowledge that I have been provided: the OCH Patient's Bill of Rights; the Long-Term Care Services ("Swing Bed") Patient's Bill of Rights, if applicable; and information regarding 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. 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.

Nondiscrimination Policy. I acknowledge receipt of the document "Nondiscrimination Policy." OCH will not discriminate on the basis of race, color, religion, sex, national origin, disability, age, sexual orientation, or veteran's status in providing services and benefits, including transfers or referrals to or from the facility.

Medicare/Tricare/Champus. I acknowledge receipt of "An Important Message from Medicare/Tricare/Champus."

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."

Patient/Parent

Date

Witness

Date

Guarantor/Guardian

Date

Place Patient Label Here



NOTICE

**PLEASE BE ADVISED OF THE FAILED
APPOINTMENT POLICY:**

- 1. IT IS YOUR RESPONSIBILITY TO CALL OUR OFFICE IN THE EVENT THAT YOU CAN NOT KEEP A SCHEDULED APPOINTMENT AT THIS OFFICE.**
- 2. IT IS YOUR RESPONSIBILITY TO CONTACT THE FACILITY YOU HAVE BEEN REFERRED TO BY OUR CLINIC IF YOU CAN NOT KEEP THAT APPOINTMENT.**
- 3. THREE MISSED APPOINTMENTS WITHOUT A PRIOR PHONE CALL TO ANY FACILITY COULD BE TERMS FOR DISMISSAL FROM THIS PRACTICE.**

Patient Signature

Print Name

Name: _____

Date: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problem?

(Use "✓" to indicate your answer)

	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For Office Coding 0 + + +
= **Total Score:**

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult At All

Somewhat Difficult

Very Difficult

Extremely Difficult

OZARKS COMMUNITY HOSPITAL

2828 N. National Ave. • Springfield, MO 65803

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: ____/____/____

Address: _____ City: _____ State: _____ Zip Code: _____

Social Security #: _____ Phone: _____

I request my protected health information (PHI) from:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> OCH-Springfield | <input type="checkbox"/> Behavioral Health | <input type="checkbox"/> Northside Clinic | <input type="checkbox"/> Primrose Clinic |
| <input type="checkbox"/> OCH-Gravette | <input type="checkbox"/> Christian County Clinic | <input type="checkbox"/> North Pediatrics | <input type="checkbox"/> Medical Offices Clinic (specialty) |
| | <input type="checkbox"/> Gravette Clinic | <input type="checkbox"/> Pain Clinic | <input type="checkbox"/> Webster County Clinic |
| | <input type="checkbox"/> Lawrence County Clinic | <input type="checkbox"/> Polk County Clinic | <input type="checkbox"/> Jasper County Clinic - Webb City |
| | <input type="checkbox"/> Noel Clinic | <input type="checkbox"/> Primary Care Clinic | <input type="checkbox"/> Jasper County Clinic - Carthage |
| | <input type="checkbox"/> Wellpointe Clinic | <input type="checkbox"/> Evergreen Clinic | |

Other Hospital or Provider:

I authorize and request OZARKS COMMUNITY HOSPITAL to:

_____ **RELEASE** information to: _____ **OBTAIN** information from:

Name: _____

Address: _____
City State Zip Code

Phone: _____

Fax or Mail Information To:
OCH Jasper County Clinic: Carthage
2425 Fairlawn Ave.
Carthage, MO 64836
Phone: 417-237-0604
Fax: 417-237-0613

I authorize the following PHI to be released from my medical record (s):

- | | |
|---|--|
| <input type="checkbox"/> Abstract/Hospital Summary (Dictated reports/Lab/Radiology) | <input type="checkbox"/> Complete Medical Record |
| <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Clinic Visits |
| <input type="checkbox"/> Laboratory Report (s) | <input type="checkbox"/> Psychotherapy Visits |
| <input type="checkbox"/> Radiology Report (s) | <input type="checkbox"/> Itemized Billing |
| <input type="checkbox"/> Radiology Film/Image (s) | <input type="checkbox"/> Other _____ |

Covering the period of health care from:

From Date (s): _____ to Date (s) _____

Purpose for requesting information:

Legal Insurance Personal Continuation of Care

By signing this authorization form, I understand that:

- Requests for copies of medical records and/or non-document material may be subject to copying fees.
- PHI may include reports relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment of alcohol/drug abuse.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the Health Information Management Department. Revocation will not apply to information that has already been released in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire 90 days from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

Patient/Authorized Representative Signature: _____ Date: _____

Authority to Sign if not patient: _____

OFFICE USE ONLY

Identity of Requestor Verified: Photo ID Matching Signature Other (specify) _____

Verified By: _____