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**

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 _____
OTHER _____

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 testing, to include HIV testing, 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."

_____ _____
Patient/Parent Date

_____ _____
Witness Date

_____ _____
Guarantor/Guardian Date

Place Patient Label Here

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

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: _____

OZARKS COMMUNITY HOSPITAL

28 N. National Ave. • Springfield, MO 658(

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:

- ☐ OCH-Springfield
- ☐ OCH-Gravette
- ☐ Behavioral Health
- ☐ Christian County Clinic
- ☐ Gravette Clinic
- ☐ Jasper County Clinic
- ☐ Lawrence County Clinic
- ☐ Noel Clinic
- ☐ Northside Clinic
- ☐ North Pediatrics
- ☐ Pain Clinic
- ☐ Polk County Clinic
- ☐ Primary Care Clinic
- ☐ Primrose Clinic
- ☐ Medical Offices Clinic (specialty)
- ☐ Webster County Clinic
- ☐ Wellpointe Clinic
- ☐ 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:
Christian County Clinic
105 Ridgecrest Ave #9
Nixa, MO 65714
Phone: 417-725-8250
Fax: 417-725-8253

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

- ☐ Abstract/Hospital Summary (Dictated reports/Lab/Radiology)
- ☐ Emergency Room Record
- ☐ Laboratory Report (s)
- ☐ Radiology Report (s)
- ☐ Radiology Film/Image (s)
- ☐ Complete Medical Record
- ☐ Clinic Visits
- ☐ Psychotherapy Visits
- ☐ Itemized Billing
- ☐ 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: _____