



## Adult Patient Registration

**Please Print Clearly**

Date \_\_\_\_\_

Physician \_\_\_\_\_

**Patient Information**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone Number \_\_\_\_\_

Work Phone Number \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male  Female

Single  Married  SSN \_\_\_\_\_

Name of Employer \_\_\_\_\_

Emergency Contact \_\_\_\_\_

(NOT living with you)

Emergency Contact phone \_\_\_\_\_

Relationship to Emergency Contact \_\_\_\_\_

Primary Insurance \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Local Pharmacy \_\_\_\_\_

(Please list name and location)

Mail-In Pharmacy \_\_\_\_\_

Email Adress \_\_\_\_\_

**Responsible Party** (person who will receive statements)

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Spouse Information**

Name \_\_\_\_\_

Cell Phone Number \_\_\_\_\_

Work Phone Number \_\_\_\_\_

**Insured Information**

(only provide if other than patient)

*Primary Ins:* Insured Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

*Secondary Ins:* Insured Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Additional Information**

Race \_\_\_\_\_

Ethnicity \_\_\_\_\_

(Options: Hispanic, Non-Hispanic, Refuse to Report)

Language \_\_\_\_\_

**Patient Name** \_\_\_\_\_

**Consent to Treat**

I, the undersigned, as the patient or his/her authorized representative, hereby consent to treatment by the physicians and staff of the Hendricks Regional Health Medical Group. I further authorize such medical services on any subsequent visits. I have the right to revoke this consent at any time by communicating such decision in writing.

**Authorization to Release Information and Pay Benefits**

I hereby authorize Hendricks Regional Health physicians, agents and employees to release to my insurance carrier or third party payers a copy of my medical records in connection with Workmen's Compensation or to release my medical records to others responsible for insurance claims and investigations.

I further authorize my insurance company to pay directly to Hendricks Regional Health all payments for medical services rendered.

**Guarantee of Accounts**

I agree that I am financially responsible for any charges not covered by my insurance. I shall also be responsible for all reasonable costs of the collection of this account, including but not limited, client collection fees, collection agency fees, late fees, rebilling charges, interest, reasonable attorney fees and court costs on any outstanding balances. I understand I may be contacted by mail, e-mail, text messaging or any phone number associated with this account by Hendricks Regional Health and/or their agents in an effort to collect payment on my accounts. This may include the use of pre-recorded/ artificial voice messages and/or use of an automatic dialing device, as applicable.

**Notice of Privacy Practices and Office Policies**

I was offered a copy of the Hendricks Regional Health Notice of Privacy Practices and the office policy.

**Medicare Signature on File (if applicable)**

I request that payment of authorized Medicare benefits be made on my behalf to Hendricks Regional Health Medical Group providers for any services furnished me by the listed provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown.

\_\_\_\_\_  
Patient or Legal Guardian Signature

\_\_\_\_\_  
Relationship To Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness



At Hendricks Regional Health we take the privacy of your health information seriously. We will not release a patient's health information outside of the allowed exceptions spelled out in our Notice of Privacy Practices without your verbal or written permission.

This form gives you the opportunity to tell us who we can speak to regarding your health information. You are not required to list anyone and you can change who we are permitted to speak to at any time by completing a new form.

I authorize Hendricks Regional Health Medical Group physicians and/or staff to speak to the individuals listed below regarding my health and billing information. I understand that I can revoke this authorization at any time by completing a new form.

Name	Relationship
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Witness



**Early TB Prescreen Checklist**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 (Please Print)

This is a required screening checklist. Please circle yes to any of the questions that apply. Answering yes does not necessarily indicate that you have TB.

- |  |     |    |
|--|-----|----|
| Persistent cough greater than 3 weeks                | yes | no |
| Coughing up blood                                    | yes | no |
| Frequent night sweats                                | yes | no |
| Low-grade fever (100 - 101 F) greater than 3 days    | yes | no |
| Recent unexplained weight loss with loss of appetite | yes | no |
| Previous Active TB disease                           | yes | no |
| Chest x-ray suggest rule out TB                      | yes | no |

**In Office Use Only:**

Comments for yes responses \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## INDIANA ADULT & PEDIATRIC MEDICINE

Audrey M. Abell, MD  
Linda S. DeCesare, MD  
Tyler M. Fromm, MD

Kelly M. Glover, MD  
John N. Kersteff, MD  
Laura J. Nelson, MD

John E. Unison, MD  
S. John Voiles, MD  
Julie A. Walters, MD



**Hendricks**  
Regional Health  
MEDICAL GROUP

I would like to be web-enabled to access my personal health information via the HRH Medical Group web portal. I understand that a link to the portal as well as my user ID and password will be e-mailed to the e-mail address provided below.

I also understand that if the e-mail below is a shared e-mail or I share my user ID and password with anyone they will have access to my personal health information.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

E-mail address: \_\_\_\_\_

(please print)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_