Registration Form - WASA

Today's Date:	PCP:	
PATIENT INFORMATION		
Patient's Last Name:	First:	Middle:
If patient is a minor, Parent/Guardian Name:		
Date of Birth:	Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:
Email Address:	Preferred Pharmacy:	
Social Security Number:	Driver's License No. & State:	
Race:	Ethnicity: ☐ Hispanic ☐ Non-Hispanic	Preferred Language:
Employer:	Employer Address:	Employer Phone:
Emergency Contact:	Relationship to Patient:	Phone Number:
INSURANCE INFORMATION		
Subscriber Name:	Subscriber DOB:	
Policy Number:	Group Number:	Relationship to Policy Holder:
GUARANTOR INFORMATION (if patient is a minor)		
Person Responsible for Account:	Birth Date:	Relationship to Patient:

DCH Health System

Clinic Registration WASA

* A M . R E G . W A S A *

West Alabama Surgical Associates - WASA
New Patient Health History

NAME:_____ DATE:_____

WEIGHT:_____ HEIGHT:_____

1) ALLERGIES: PLEASE CHECK IF YOU HAVE HISTORY OF ALLERGY TO THE FOLLOWING:

____NO KNOWN DRUG ALLERGIES
____PENICILLIN
____KEFLEX (CEPHALOSPORINS)
____CODEINE
____MORPHINE
____DEMEROL
____OTHER NARCOTICS (List: _____)
____LIDOCAINE, NOVOCAINE; or ANESTHETICS
____CIPRO, FLOXIN
____ERYTHROMYCIN
____SULFA DRUGS
____MACRODANTIN
____IODINE or BETADINE
____ASPIRIN
____IBUPROFEN (Advil/Motrin)
____TETANUS or OTHER SERUMS
____ALLERGY TO ANY OTHER MEDICATION NOT LISTED (List:_____)
____FOOD ALLERGIES (List:_____)

LATEX ALLERGY? YES or NO
X-RAY DYE ALLERGY? YES or NO

2) PLEASE LIST YOUR CURRENT MEDICATIONS:

____I do not take any medication.

Name of Medication	Dosage	How Often Do You Take

3) PLEASE LIST ALL PRIOR SURGERY:

Surgery	Date of Surgery

4) YOUR PERSONAL MEDICAL HISTORY: PLEASE CHECK IF YOU HAVE THE FOLLOWING:

____DIABETES
____HYPERTENSION
____HEART TROUBLE (Type: _____)
____BLOOD THINNERS (Name: _____ Why? _____)
____BLEEDING TENDENCY DISORDER
____CANCER (Type: _____)
____REFLUX
____COPD
____STROKE/TIA
____THYROID DISEASE/PROBLEMS
____SEIZURES
____ARTHRITIS/GOUT
____AIDS/HIV
____OTHER DISEASE or ILLNESS NOT LISTED (List: _____)

**Do you use C-PAP machine? NO or YES

5) Have you had a colonoscopy? NO ____ YES ____ (Most recent date _____)

6) Have you had a pneumonia shot? NO ____ YES ____ (Most recent date _____)

Have you EVER had a flu shot? NO ____ YES ____

7) YOUR FAMILY MEDICAL HISTORY: HAS ANY PERSON RELATED BY BLOOD, HAD ANY OF THE FOLLOWING:

____CANCER: Relationship _____ Type _____ Age _____
____HIGH BLOOD PRESSURE: Relationship _____
____STROKE: Relationship _____
____DIABETES: Relationship _____
____HEART DISEASE: Relationship _____ Type _____ Age _____
____EPILEPSY/SEIZURES: Relationship _____
____BLOOD OR CLOTTING DISORDER: Relationship _____
____PROBLEM WITH ANESTHESIA: Relationship _____
____PSYCHIATRIC ILLNESS: Relationship _____ Type _____
____OTHER DISEASE/ILLNESS NOT LISTED: Relationship _____ List _____

8) SOCIAL HISTORY:

MARITAL STATUS: Single ____ Married ____ Separated ____ Divorced ____ Widowed ____

USE OF ALCOHOL: Never ____ Rarely ____ Moderate ____ Daily ____

USE OF DRUGS: Never ____
Former User ____ Type: _____
Current User ____ Type: _____

USE OF TOBACCO: Never ____
Former User ____ Type _____ Packs per day _____ # of years _____
Current User ____ Type _____ Packs per day _____ # of years _____

9) PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING:

___ ***GOOD GENERAL HEALTH LATELY***
___ RECENT WEIGHT CHANGE (GAIN or LOSS)
___ FEVER
___ FATIGUE
___ HEADACHES

EYES:
___ WEAR GLASSES/CONTACTS
___ BLURRED/DOUBLE VISION
___ GLAUCOMA

ENT/MOUTH:
___ HEARING LOSS/RINGING
___ CHRONIC SINUS PROBS
___ NOSE BLEEDS
___ BLEEDING GUMS
___ SORE THROAT/VOICE CHANGE
___ SWOLLEN GLANDS IN NECK

CARDIOVASCULAR:
___ HEARTTROUBLE
___ CHEST PAIN/ANGINA
___ HEART PALPITATIONS
___ SWELLING FEET/HANDS/ANKLES
___ PAIN IN LEGS WITH WALKING

RESPIRATORY:
___ CHRONIC/FREQUENT COUGH
___ SPITTING UP BLOOD
___ SHORTNESS OF BREATH
___ ASTHMA/WHEEZING

GASTROINTESTINAL:
___ LOSS OF APPETITE
___ CHANGE IN BOWEL
___ NAUSEA OR VOMITING
___ FREQUENT DIARRHEA
___ CONSTIPATION
___ PAINFUL BOWEL MOVEMENTS
___ RECTAL BLEEDING/BLOOD IN STOOL
___ ABDOMINAL PAIN
___ HEARTBURN/INDIGESTION
___ ULCER-STOMACH or DUODENAL
___ DIVERTICULOSIS/DIVERTICULITIS

ENDOCRINE:
___ THYROID DISEASE
___ DIABETES
___ EXCESSIVE THIRST
___ EXCESSIVE URINATION
___ HEAT or COLD INTOLERANCE
___ SKIN BECOMING DRY

GENITOURINARY:
___ URINARY TRACT INFECTIONS
___ FREQUENT URINATION
___ BURNING/PAINFUL URINATION/BLOOD in URINE
___ KIDNEY STONES
___ MALE-TESTICLE PAIN
___ FEMALE-# of PREGNANCIES _____
AGE WHEN YOU STARTED PERIOD _____
AGE WHEN 1st CHILD BORN _____
DID YOU BREAST FEED?_____
BIRTH CONTROL PILLS? _____# of YEARS _____
DATE of LAST MENSTRUAL CYCLE_____

MUSCULOSKELETAL:
___ DIFFICULTY AMBULATING
___ AMBULATES WITH A WHEELCHAIR
___ AMBULATES WITH A CANE
___ AMBULATES WITH A WALKER
___ HISTORY OF FALL (IF YES: MOST RECENT DATE_____)
___ JOINT PAIN
___ JOINT STIFFNESS/SWELLING
___ WEAKNESS OF MUSCLES/JOINTS
___ BACK PAIN
___ COLD EXTREMITIES

SKIN & BREAST:
___ RASH OR ITCHING
___ CHANGE IN SKIN COLOR/HAIR/NAILS
___ VARICOSE VEINS
___ BREAST PAIN
___ BREAST LUMP
___ BREAST DISCHARGE

NEUROLOGICAL:
___ FREQUENT/RECURRING HEADACHES
___ LIGHTHEADED/DIZZINESS
___ CONVULSIONS/SEIZURES
___ NUMBNESS/TINGLING
___ TREMORS
___ PARALYSIS
___ STROKE
___ HEAD INJURY

PSYCHIATRIC:
___ MEMORY LOSS/CONFUSION
___ NERVOUSNESS
___ DEPRESSION
___ INSOMNIA

HEMATOLOGIC/LYMPHATIC:
___ BLEEDING/BRUSING EASILY/ANEMIA
___ ENLARGED GLANDS/LYMPH NODES

GENERAL CONSENT: A patient's care plan is established by his or her physicians; and, in most instances, the hospital is not liable for any act or omission when following the instructions and/or orders of the patient's physician(s). I consent to any examinations, tests, treatment, procedures, therapies or medications rendered to the patient under the general and special instructions of the physician. I consent to being photographed for clinical purposes. Additional consents may be required for specific examinations, procedures, or therapies.

I understand that <u>most</u> physicians providing services to the patient are independent contractors and are not employees or agents of the hospital. I also understand that I likely will receive separate bills for physicians or other healthcare professionals that may render treatment and services to me.

STATEMENT OF FINANCIAL RESPONSIBILITY: Unless otherwise prohibited, the patient unconditionally guarantees payment in full to DCH Healthcare Authority (DCH), its physicians, and other healthcare professionals that may render treatment and services to me. I understand that any unpaid balance is due in full within 30 days of receipt of the initial statement unless other arrangements for payment are made. The patient further agrees to pay any cost or expense, including court costs and attorney fees associated with the necessary collection of my account. **However, I understand that certain patients may qualify for substantial financial assistance based on individual circumstances and need. This assistance may reduce or eliminate the amounts for which the patient is responsible. Information regarding financial assistance may be obtained by calling 205 343 8321.**

I hereby authorize and consent to the release of all medical and personal information (including but not limited to my home phone, cell phone, work phone, address and email address) by or to the hospital and by or to any and all healthcare professionals involved in my care; interpretation of test results; account billing and collection; payment posting and/or processing; or related healthcare functions. This authorization shall remain in effect until such time as all account balances extending from this encounter have been fully satisfied. I authorize the hospital and all clinical providers who have provided care or interpreted my tests. I authorize DCH , or any of its affiliates, agents, contractors or business associates, to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by pre-recorded forms of voice messaging systems, by electronic mail owned by or used by the guarantor/responsible party, by text messages, by telephone or by cell phone for reasons related to the services I received from DCH or payment for services I received at DCH, including but not limited to debt collection purposes. I further understand and acknowledge that my consent in receiving the aforementioned communications is not required nor is it a preceding condition to receiving health care services from DCH.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign and authorize and direct payment to DCH or any other healthcare provider of all insurance benefits, including those provided under Medicare and Medicaid under Title XVIII/XIX of the Social Security Act, payable under their respective terms for my services and medical treatment. Unless otherwise provided by law, the filing or processing of any claim shall not be a condition precedent to any collection of any unpaid charges, and shall not be construed as the assumption of any duty by DCH with regard to the insurance.

To the extent allowed by law, I remain responsible for any portion of the hospital bill not paid by insurance, including co-insurance, denied claims or deductibles or reduced or forgiven under any applicable financial assistance program. I understand that if a private room is requested or provided, I am responsible for any additional unpaid charges incurred.

RELEASE OF INFORMATION: In addition to that provided above, the hospital and its physicians may disclose all or any part of the patient's record when such disclosure is necessary for my continued treatment, the payment for the services I receive, for healthcare operation or as may be required or allowed by applicable law.

For detailed information about how your healthcare information may be used, please review DCH Health System's Notice of Privacy Practices. I permit a copy of these authorizations and assignment to be used in place of the original.

PERSONAL VALUABLES: It is understood and agreed that DCH is not responsible or liable for the loss, theft or damage to any money or any personal property, however described and regardless of the mechanism of loss, unless such property is deposited with the hospital for safekeeping.

AUTHORIZATION FOR MEDICATION ASSISTANCE PROGRAMS: DCH participates in programs with some drug manufacturers that can offer assistance in providing medications for low-income, non- and under-insured patients who meet certain standards. I grant DCH permission to send the patient's medical and financial information to these drug manufacturers for the purposes of applying for aid. I am also granting DCH, or its agents, permission to complete the drug manufacturers' application forms and to sign on the patient's behalf.

Patient Signature _____ Date/Time _____

Patient's Representative (if patient is unable to sign) _____ Date/Time _____ Representative's Relationship to Patient _____

Witness Signature _____ Date/Time _____

If consent is by phone:

Name of Person Giving Consent _____ Relationship to Patient _____

Witness Signature _____ Date/Time _____

PATIENT AUTHORIZATION FOR PERSONAL REPRESENTATIVE - WASA

Please print all information, then sign, date and time form at bottom.

Name of Practice: _____

Patient Name: _____

Social Security Number: _____ Date of Birth: _____

Purpose of request: I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

1. Name of Personal Representative _____
   Address/Phone: _____
   Relationship to patient: ☐ Spouse ☐ Parent(s) ☐ Child ☐ Other _____
2. Name of Personal Representative _____
   Address/Phone: _____
   Relationship to patient: ☐ Spouse ☐ Parent(s) ☐ Child ☐ Other _____
3. Name of Personal Representative _____
   Address/Phone: _____
   Relationship to patient: ☐ Spouse ☐ Parent(s) ☐ Child ☐ Other _____
4. Name of Personal Representative _____
   Address/Phone: _____
   Relationship to patient: ☐ Spouse ☐ Parent(s) ☐ Child ☐ Other _____

- **Description of information to be disclosed:** I authorize the practice to disclose all of my protected health information to my designated personal representative, including but not limited to, past and current medical information, billing information, appointment scheduling, prescriptions, etc.
- **Expirations or termination of authorization:** This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.
- **Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

Redisclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

Secure Communication -- Note that regular email is not secure, and it is possible for your PHI to be compromised during transmission to, or from our practice. Do not designate email as your preferred method of communication if this is of concern to you.

Signature of Patient (Parent or Legal Guardian)

Date/Time

Copies of signed authorizations are available upon request.

DCH Health System

Authorization for Personal Representative WASA

AM-AOR-WASA

Request to Communicate

I authorize West Alabama Surgical Associates to directly, or through its authorized vendor, contact me by the means provided below. Please do not respond to DCH text messages or emails with your protected health information. Under HIPAA, text messages and unencrypted emails are not considered a safe form of communicating health information and messages may be intercepted by others during transmission. Information that may be sent to help me or my child stay

- timely reminders about needed doctor visits or schedule changes
- detailed messages
- how to get help scheduling patient visits
- information to help manage illnesses
- requests to review the quality of healthcare services provided and/or participate in a survey
- any other healthcare related function

I understand **I do not** have to provide any of the communication sources, but if I do it is my responsibility to notify West Alabama Surgical Associates of any changes.

Home Phone: _____
Ex: 123-456-7890
☐ You may leave a detailed message
☐ I opt out of receiving reminders or other information to this number

Cell Phone: _____
Ex: 123-456-7890
☐ You may leave a detailed message
☐ I opt out of receiving reminders or other information to this number

Work Phone: _____
Ex: 123-456-7890
☐ You may leave a detailed message
☐ I opt out of receiving reminders or other information to this number

Email: _____
☐ You may leave a detailed message
☐ I opt out of receiving reminders or other information to this email

Please Note: *If you do not mark the box to leave a message, we will not leave a message.*

Do you give permission for us to contact or leave information with another person? ☐ Yes ☐ No

List name of person(s): _____

Contact phone number: _____
Ex: 123-456-7890

Does patient want to participate in AL Health Info Exchange? ☐ Opt In ☐ Opt Out ☐ Patient Unable to Respond

Signature of Patient/Patient Representative	Date/Time	Relationship of Patient Representative

DCH Health System®

Request to Communicate
WASA

* A M . R E Q C O M M . W A S A *

Acknowledgement of HIPAA Omnibus Final Rule
Notice of Privacy Practices - WASA

I, _____ , acknowledge that I either received the DCH Health System Notice of Privacy Practices or had the notice made available to me on the date I received healthcare services.

_____ _____
Patient Signature Date/Time

_____ _____ _____
Patient's Representative (if patient is unable to sign) Date/Time Relationship to Patient

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Good Faith Effort

I, _____ , a DCH Health System employee, certify that the facility employees and agents made a good faith effort to obtain a written acknowledgement of receipt of the *Acknowledgement of HIPAA Omnibus Final Rule Notice of Privacy Practices,* however, for the following reasons the written acknowledgement was not obtained:

_____ _____
Employee Date/Time