520 S SANTA FE SUITE 240
PHONE: 785-452-7366
FAX: 785-452-7354

Patient Name:_________________________________ **Patient DOB:** _______________
Patient Phone Number: ___________________________

Infection Control Travel Screening

We want to keep our patients, or employees and our community safe. Please help us by answering the following questions.

1. Have you traveled to or from West Africa in the past 30 days, or do you have a known exposure to anyone who has traveled to or from West Africa in the past 30 days? ☐ Yes ☐ No

   If no, please complete the bottom section and return to the receptionist.

2. Do you currently have a fever, severe headache, nausea, vomiting or unexplained bleeding? ☐ Yes ☐ No

   If no, please complete the bottom section and return to the receptionist.

If YES to both questions STOP. We are unable to provide treatment at this facility.
Please proceed to the Salina Regional Health Center Emergency Department for evaluation.

_____________________________________ _______________________
Name (Printed) Date of Birth

_____________________________________ _______________________
Signature Date

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Patient Name:____________________________________ **Patient DOB:** _________________
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____

Medicare Secondary Payer Questionnaire

(To be completed for All Medicare Patients ONLY)

Patient Name: ____ **Date of Birth:** _______________

Payer Questions

1. Are you receiving Black Lung Benefits?
Yes No

2. Are the services to be paid by a government program such as a Research Grant?
Yes No

3. Has the Department of Veteran Affairs (DVA) authorized and agreed to pay for care at this facility?
Yes No

4. Is this medical condition due to an accident of any kind?
Yes No
If Yes was the injury:
Work related ______
Auto related ______
Injury in your home ______
Other ______ Please explain: ________________________________

5. Is the patient covered by an employer's health insurance plan through their own employment or that of a family member?
Yes No

6. Are you entitled to Medicare based on:

Age:	Yes	No
Disability:	Yes	No
ESRD: (end stage renal disease)	Yes	No

Date: __________________________________

Patient's Initials: ________________________

Initials of Interviewer: ___________________

Salina Regional Orthopedic Clinic
Salina Regional Health Center

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Patient Name:___________________________________ **Patient DOB:** ________________
Patient Phone Number: _____________________________

TREATMENT AUTHORIZATION AND PRIVACY ACKNOWLEDGEMENT

Salina Regional Health Center Physician Clinics, including its acute care rehabilitation unit, emergency departments, outpatient surgery and outpatient departments are herein referred to as "medical group".

1. CONSENT FOR TREATMENT: I consent to x-ray examinations, laboratory procedures, anesthesia, medical or surgical treatment, hospital services, and/or other services rendered under the general and special instructions of my attending or consulting physicians. I understand that my treatment is under the control of my attending physicians, their assistants or designees. Further, I understand that among those who attend patients at this medical group are medical, nursing, and other health care personnel in training and volunteer student observers who, unless requested otherwise, may be present during patient care as a part of their education. If admitted, I understand that if I desire private duty nursing care, it is agreed that such must be arranged by myself or my family and the medical group shall be released from any and all liability arising from such are. I understand that if further diagnostic studies or treatment procedures that are considered major in nature, such as an operation, are required, I will be asked to give specific consent for these prior to them being carried out. I understand that the practice of medicine and surgery is not an exact science, and acknowledge that no guarantees have been made to me as to the results of care, treatment, and the provision of medical services.
2. CONSENT FOR BLOOD/BODY FLUID TESTING: In the event that a health care worker or emergency response person(s) is suspected to have had exposure to my blood and/or body fluids or if it is likely that a health care worker or emergency response person(s) is exposed to my blood and/or body fluids, due to my illness or an uncommon rare disease, I consent to have the medical group determine by serological testing whether or not my blood contained contagious viruses. I understand that the information obtained from such tests will only be disclosed as necessary to adequately protect my own health and the health of my family, as well as the health of those health care personnel or emergency response person(s) who may have been or become involved in my treatment.
3. CONSENT TO DISPOSAL OF TISSUE/FLUIDS/SPECIMENS: I agree that the medical group may utilize, destroy, or dispose of any tissues, fluids, or specimens taken from me during treatment.
4. AGREEMENT TO PAY FOR SERVICES: I agree, whether I sign this as an agent or as a patient, that in consideration of services to be rendered to me, I hereby individually obligate myself to pay the charges of the medical group in accordance with its regular rates and terms.
5. ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign my insurance benefits otherwise payable to me to be paid directly to the medical group. I understand that I am financially responsible for charges not covered by this assignment and further agree to guarantee full payments of all charges not covered by third-party payers. If I do not pay the amount due as I agreed, I agree also to pay the reasonable cost of collection, including but not limited to attorney fees and collection agency fees.
6. MEDICARE/MEDICAID/INSURANCE BENEFITS: I authorize the medical group to release to Medicare and/or Medicaid, to the Social Security Administration and/or its intermediaries or carriers, and to any peer review organizations, any information needed for this or a related Medicare and/or Medicaid claim. I request payment of authorized benefits to be made on my behalf to the medical group for services furnished me, and to the physicians involved for their services, including those physicians/specialists doing their own billing, while I was a patient in the Hospital.
7. AUTHORIZATION FOR DISCLOSURES TO REGULATORY OR OVERSIGHT BODIES AND
WAIVER OF ACCOUNTING: I understand that as part of its health care operations, the medical group is required by law to disclose certain of my protected health information to public health agencies, regulatory and oversight bodies. I hereby authorize the hospital to make such disclosures without any accounting of such disclosures since they are required by law.
8. CONTRABAND WEAPONS/DRUGS: I agree that should the medical group find contraband weapons and/or nonprescription drugs not sold over-the-counter with my possession, these items will be confiscated and the police will be contacted.
9. TOBACCO PRODUCTS: Salina Regional Health Center is a tobacco free campus. Tobacco use is prohibited on all hospital owned properties including outdoor areas, stairways, parking lots and garages, medical office building properties and entryways. Please send your smoking materials home. If you do smoke, please consider asking your nurse regarding information on smoking cessation programs.
10. PROVIDER NON-DISCRIMINATION ACT: I understand that this is an equal opportunity institution.
There is no discrimination because of race, color, religion, natural origin, age, sex, handicap, or inability to pay.
11. PATIENT RIGHTS INFORMATION: I have reviewed/received "Patient Right and Responsibilities" and understand my rights as described in that document.
12. NOTICE: Your health information related to work-related illnesses or injuries or to medical surveillance of the work place may be disclosed to your employer.

PATIENT/PERSONAL REPRESENTATIVE MUST COMPLETE BY SIGNING OR INITIALING

X____
PATIENT/PERSONAL REPRESENTATIVE INITIAL

13. ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES. I hereby acknowledge that I have received a copy of the medical group's Notice of Privacy Practices.

X____
PATIENT/PERSONAL REPRESENTATIVE INITIAL
I certify that I have read and fully understand this document and that I have received a copy of it. I, as the patient/personal representative, agree to sign this document indicating that I agree with all of its terms and statements.

X____ _________________ ___________
Patient/Personal Representative Signature Relationship to Patient Date

____ ________________
Signature, Witness Date

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Patient Name:__________________________________ Patient DOB: ________________
Patient Phone Number: ____________________________

Salina Regional Health Center Contact List /Authorization to Verbally Release Protected Health Information Contact List:

I authorize Salina Regional Health Center health care providers to provide verbal information concerning my health care to those that I have listed below while I am a patient. Verbal requests for information from other friends, family, caretakers, concerning my health care will not be disclosed without an additional authorization from me. (Exception: Health Information may be disclosed without authorization in an emergency situation or if SRHC determines that the disclosure is in my best interest and the information disclosed is limited to those persons involved in my care).

Name of Family Member/Caretaker	Relationship	Phone Number	Allow Messages
			Y / N
			Y / N
			Y / N

I may revoke this authorization at any time by notifying my nurse. I have read the above and authorize verbal disclosure of my medical condition. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be-disclosed and no longer protected by those regulations.

X__________________________________ X____
Date Signature of Patient or Authorized Agent/Representative

__________________________________ ____
Printed name of authorized agent/representative Relationship to patient

__________________________________ ____
Address of Authorized agent/representative Telephone # of authorized agent/representative

(Note: Any requests for restriction/communication accommodation should be forwarded to the Privacy Office for approval on the "Request for Disclosure Restriction/Communication Accommodation Form")

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Patient Name:___________________________________ **Patient DOB:** ________________
Patient Phone Number: _____________________________

____

MEDICATION LIST

Preferred Pharmacy:

Medication Name	Dose	How often are you taking?	What is the medicine for?	Reviewed Date
Allergies:				

Salina Regional
Orthopedic Clinic
Salina Regional Health Center

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Patient Name:______________________________ **Patient DOB:** _______________
Patient Phone Number: ___________________________

PAIN HISTORY

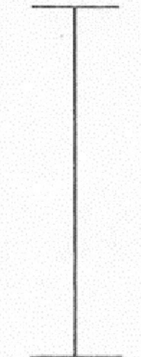
Name: ____________________________ *Date:* _______________

Please mark the areas on your body where you feel the following sensations, using the symbols below :

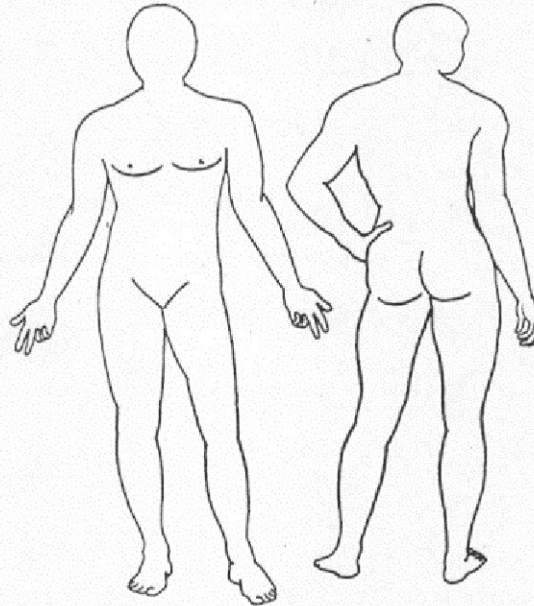
= **NUMBNESS**
X **BURNING**
/ **STABBING**
● **PINS / NEEDLES**

OVERALL PAIN RATING

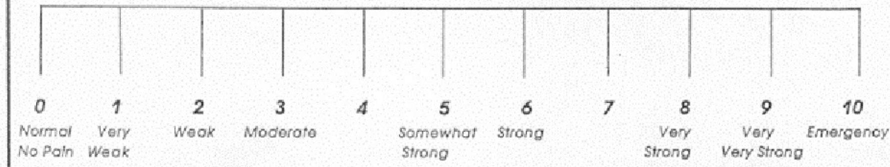
PAIN AS BAD AS IT CAN BE



NO PAIN AT ALL



PAIN INTENSITY (Circle One)



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Patient Name:___________________________________ **Patient DOB:** ________________
Patient Phone Number: _____________________________

REGISTRATION FORM

PATIENT INFORMATION
Date: ________________________

Patient Name: ____Maiden/Other Name______________________
First MI Last

Birth Date: _____________________________ SSN: _____________________________ Sex: ______________

Race: (circle) Asian Black Hawaiian Hispanic Native American White Other N/A

Mailing Address: ____

City: ____ State: ______________ Zip: ___________

Home Phone: _______________________________________ Cell Phone: ____________________________

Email Address: _______________________________________

(circle): Single Married Widowed Divorced Other: _________________

Religion: _______________________ Affiliation: ________________________

Referring Physician: ______________________________ **Primary Physician**: __________________________

EMPLOYMENT
(circle): Full-time Part-time Retired Self-Employed Unemployed Disabled Minor

If Disabled, are you disabled due to your current pain? Yes No

Employer: ____

Address: ____

City: ___________________________ State:______ Zip: _______

Phone: _____________________ (Ext: ________)

Patient Name:_________________________________ Patient DOB: _______________
Patient Phone Number: ___________________________

PERSON RESPONSIBLE FOR BILL
(circle): Same as Patient Parent/Guardian Other: _________________
(if other than patient please fill in the following information)

Name: ____ SSN: ________________________

Address: ____ Phone Number: _______________

City: ____ State: _______________

Zip: ______________

(circle): Full-time Part-time Retired Self-Employed Unemployed Disabled

We cannot file insurance without a copy of your insurance cards for verification of coverage

INSURANCE
Primary Health Insurance: _________________________________ Member ID #: ______________________________

Policy Holder: (circle): Same as Patient Spouse Parent/Guardian Other: _____________
(If other then patient please fill in the following information)

Name of Insured (policy holder): ____

Address of Insured: ____

City: ____ State: _______________________ Zip: _________________

Home Phone: ____ Other Phone: ______________________________

DOB of insured: ___________________ SSN of insured: _________________ Sex of insured: ________

Secondary Insurance: ___________________________________ Member ID #: ________________________________

Policy Holder: (circle): Same as Patient Spouse Parent/Guardian Other: ______________
(If other then patient please fill in the following information)

Name of Insured (policy holder): ____

Address of Insured: ____

City: ____ State: _______________________ Zip: _________________

Home Phone: ____ Other Phone: ______________________________

DOB of insured: ____________________ SSN of insured: __________________ Sex of insured: ________

WORKERS COMPENSATION

* Was the illness/injury due to a work related accident / condition? (circle) Yes No Claim Number:________________

Date of injury / Illness? _________________________

Authorization Number to see Surgeon: _________________________

Claim Adjuster Name: _________________________ Claim Adjuster Phone Number: ___________________________

Claim Adjuster Address:____

Patient Name:__________________________________ Patient DOB: ________________
Patient Phone Number: ____________________________

EMERGENCY INFORMATION

Next of Kin: _______________________________ Relationship to patient: _______________________

Phone number: ______________________________

(circle): Address is same as patient   Different address (please fill in the following information)

Address: ____

City: ____ State: ___________________ Zip: ______________

Person to Notify: _______________________________________ Relationship to patient: ________________________________

Phone number: ______________________________

(circle): Address is same as patient   Different address (please fill in the following information)

Address: ____

City: ____ State: ___________________ Zip: ______________

I hereby authorize my provider to furnish my insurance company or its representative or permit my insurance company or its representative to review any information requested with respect to any illness or accident, medical history or copies of hospital and medical records. A photostatic copy of this authorization shall be considered as valid as the original. I hereby authorize payment directly to my provider for this illness or injury, of the provider's benefits otherwise payable to me, but not to exceed my indebtedness to said provider. I agree to pay the provider for all my charges whether or not covered by this assignment. The responsible party hereby agrees that the provider's office or the party responsible for the billing of these services may check credit with any source to obtain credit information. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This release may include information which may be considered a communicable or venereal disease which may include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS). I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of authorizations.
I have been notified that I may receive services from the Nurse Practitioner or Physician Assistant at this location.

PLEASE NOTE: The patient portion of the bill is due at the time of service unless prior arrangements have been made.

X____ Date: _______________
Patient or Authorized Person's Signature