BEAVER DAM COMMUNITY HOSPITALS, INC.
MedicalClinics

Registration Information

Thank you for coming to see us. You can speed your care by providing the following necessary information. When finished, please give this to the receptionist. This information will then go into our computer for future visits. Thank you.

Please **PRINT** and fill out this form **COMPLETELY**. Date: _____

PATIENT:

First name _____ Middle Initial _____ Last Name _____

Previous Names (AKA) _____ Email Address _____

Street Address _____ City _____ State _____ Zip Code _____

Phone: ( ) _____-_____ Cell: ( ) _____-_____ Birth Date: _____/_____/_____ SS#: _____-____-_____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race: ☐ Asian ☐ Hispanic ☐ Indian ☐ White ☐ Unknown ☐ Other: _____

Are you seeking a family physician? ☐ Y ☐ N If not, who is your family physician?: _____

Reason for visit: _____

Date symptoms began? _____

Employer: _____ Work Phone: ( ) _____-_____

Street Address _____ City _____ State _____ Zip Code _____

Preferred pharmacy: _____ Phone: ( ) _____-_____

RESPONSIBLE PARTY: If other than patient.

First Name _____ Middle Initial _____ Last Name _____ Relationship to patient _____

Street Address _____ City _____ State _____ Zip Code _____

Birth Date: _____/_____/_____ SS#: _____-_____-_____ Home Phone: ( ) _____-_____

Employer: _____ Work Phone: ( ) _____-_____

IN CASE OF EMERGENCY CONTACT:

Name: _____ Relationship _____

Home Phone: ( ) _____-_____ Work Phone: ( ) _____-_____

INSURANCE: Provide the following information if we will be filing your insurance. Any applicable copayments will be required at the time of service. Failure to meet your copay requirement may result in the need for rescheduling of your appointment. Please have cards available for copying.

PRIMARY INSURANCE:

Subscriber Name (If other than patient): _____ DOB: _____ Policy #: _____

Group Name: _____ Group #: _____

Mail claims to: _____ Phone: ( ) _____-_____

Street Address _____ City _____ State _____ Zip Code _____

Copayment: _____ Coinsurance (%): _____ Have you met your deductible? _____

SECONDARY INSURANCE:

Subscriber Name (If other than patient): _____ DOB: _____ Policy #: _____

Group Name: _____ Group #: _____

Mail claims to: _____ Phone: ( ) _____-_____

Street Address _____ City _____ State _____ Zip Code _____

Copayment: _____ Coinsurance (%): _____ Have you met your deductible? _____

PLANNED PAYMENT METHOD: As part of your responsibility, we ask for copayments and for some services, prepayment if needed, at the time of service. If paying by CHECK or CREDIT CARD, please provide your Driver's License number.

☐ Cash _____ ☐ Check _____ ☐ Credit Card _____ Driver's License #: _____ State ___

CLINIC SERVICES AGREEMENT

(A) CONSENT TO TREATMENT:
I understand that my condition may require medical care, and I therefore voluntarily consent to receive medical services at Beaver Dam Community Hospitals, Inc. ("BDCH") Medical Clinics, including, but not limited to, diagnostic procedures, medical treatment, examinations, radiology and laboratory services, tests and treatments, medication, monitoring, general nursing care, counseling and education, and other procedures ordered by the healthcare practitioner providing services to me. I recognize that physicians or other healthcare practitioners direct my care at BDCH Medical Clinics, and that BDCH Medical Clinics is not liable for any act or omission because it follows the instructions of such physicians or healthcare practitioners. I understand that I may be released from the patient-care facilities before all of my medical problems are known or treated, and that it may be necessary for me to make arrangements for follow-up care.

(B) ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY:
In consideration for services rendered by BDCH Medical Clinics, I assign to BDCH any insurance benefits due covering incurred expenses. If I am a Medicare or Medicaid beneficiary, I request that payment of authorized Medicare or Medicaid benefits be made on my behalf for any services, including physician services, and I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, the Social Security Administration, and Wisconsin Medicaid (collectively, "Agencies"), and the agents of these Agencies, any information needed to determine these benefits or benefits for related services. I agree that these benefits otherwise payable to me shall be paid directly to BDCH and that this agreement cannot be revoked without BDCH's consent. I understand that if I receive payment directly from my insurance company, it is my responsibility to timely forward that payment to BDCH. I agree that, should the amount be insufficient to cover the entire BDCH Medical Clinics expense, I will be responsible for the payment of the difference in the event of a non-covered service. If the care is determined not to be covered by insurance, I will be responsible to BDCH for payment of the entire bill. It is further agreed that any credit balance resulting from payment of the insurance or other sources may be applied to any account owed BDCH by the same guarantor (me or my family). I agree to pay for the charges not covered by this assignment in accordance with BDCH's regular rates and terms.

I understand that I may receive invoices from physicians providing service as independent providers, such as radiologists, pathologists, etc., since these services may be billed separately from the BDCH's services.

Patient's Certification under Title XVIII and/or XIX of the Social Security Act (Medicare/Medicaid): As applicable, I certify that the information given me in applying for payment under the Title XVIII or XIX of the Social Security Act is correct. If I am a Medicare or Medicaid beneficiary, I understand I am responsible for any health insurance deductible and co-payments, as designated by the current Medicare and/or Medicaid regulations.

_____ Please initial to indicate that Patient Financial Responsibility Policy was given.

(C) NOTICE OF PRIVACY PRACTICES
____ By initialing, I acknowledge that BDCH has given me a copy of its Notice of Privacy Practices ("NPP") explaining how, when and why BDCH uses and discloses protected health information, my privacy rights related to my protected health information, and BDCH's obligations to me concerning the use and disclosure of my protected health information. The NPP provides a contact for additional information on BDCH's privacy policies should I desire more information.

(D) PATIENT'S RIGHTS
_____ By initialing, I acknowledge that I have received information regarding my Rights and Responsibilities while a patient of BDCH Medical Clinics.

(E) HEALTHCARE EDUCATION
I understand that BDCH maintains affiliation and agreements with academic institutions. I authorize that my health care services may be delivered by medical, nursing, and/or other students under appropriate supervision. I understand that I have the right to decide who participates in providing care to me and that I may decline participation of students or trainees in delivery of care to me.

By signing this form, I certify that I have read and understand the foregoing Clinic Services Agreement, and that I am competent and authorized to execute it. Unless otherwise specified or required, this Clinic Services Agreement is effective unless and until revoked, or for the course of treatment in the case of physical therapy or speech pathology services.

Date	Time	Signature of Patient
Date	Time	*Signature of Patient's Legal Guardian or Agent (and specify relationship)

Witness *Witness

Patient unable to sign consent because

_____

*When other than patient's consent is obtained, two (2) witnesses shall be present.

For Office Use Only:
If, other than in an emergency treatment situation, BDCH is unable to obtain acknowledgement of patient's receipt of the Notice of Privacy Practices, document BDCH's good faith efforts to obtain the acknowledgment and explain why the acknowledgment was not obtained:

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