Salina Regional Surgical Associates
Salina Regional Health Center

Jake Breeding, MD, FACS
Dwane Beckenhauer, MD
Justin D. Klaassen, DO
Stacy Jones, MD

REGISTRATION FORM

Date:_____ E-mail address: _____

PATIENT INFORMATION

Patient Name: _____ Age:_____Sex: ____

Mailing Address: _____

City:_____State:_____Zip: _____

Home Phone:_____Cell Phone: _____

Birth Date:_____ SSN: _____

( )Single ( )Married ( )Widowed ( )Divorce Other: _____

Religion:_____ Affiliation: _____

Referring Physician:_____Primary Physician: _____

EMPLOYMENT

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

Employer: _____

Address: _____

City:_____State:_____Zip:_____Phone:_____(Ext:_____)

PERSON RESPONSIBLE FOR BILL

( )Same as Patient ( )Parent/Guardian Other: _____

(if other than patient please fill in the following information)

Name:_____SSN: _____

Address:_____Phone Number: _____

City:_____State:_____Zip:_____Birth Date: _____

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

Employer: _____

Address: _____

City:_____State:_____Zip:_____Phone:_____(Ext:_____)

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INSURANCE

Is your visit a result of an injury? (Please circle one) **Yes** **No**

Primary Insurance: _____

Policy Holder: ( )Same as Patient ( )Spouse ( )Parent/Guardian Other: _____

(If other then patient please fill in the following information)

Name of Insured (policy holder): _____

Policy Number:_____ Group Number: _____

Address of Insured: _____

City:_____ State:_____ Zip: _____

Home Phone:_____ Other Phone: _____

DOB of insured:_____ SSN of insured:_____ Sex of insured: _____

( )Full-time ( )Part-time ( )Retired ( )Self-Employed ( )Unemployed Other: _____

Employer: _____

Address: _____

City:_____ State:_____ Zip:_____ Phone:_____ (Ext:_____)

Secondary Insurance: _____

Policy Holder: ( )Same as Patient ( )Spouse ( )Parent/Guardian Other: _____

(If other then patient please fill in the following information)

Name of Insured (policy holder): _____

Policy Number:_____ Group Number: _____

Address of Insured: _____

City:_____ State:_____ Zip: _____

Home Phone:_____ Other Phone: _____

DOB of insured:_____ SSN of insured:_____ Sex of insured: _____

( )Full-time ( )Part-time ( )Retired ( )Self-Employed ( )Unemployed Other: _____

Employer: _____

Address: _____

City:_____ State:_____ Zip:_____ Phone:_____ (Ext:_____)

We cannot file insurance without a copy of your insurance cards for verification of coverage (see next page for signature).

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EMERGENCY INFORMATION

Next of Kin:_____Phone number: _____

Relationship to patient: ( )Spouse ( )Parent/Guardian Other: _____

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

Address: _____

City:_____State:_____Zip: _____

Nearest friend or relative (outside the home): _____

Address: _____

City:_____State:_____Zip: _____

Relationship to patient:_____Phone number: _____

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_____ **x**_____

Patient or Authorized Person's Signature Date/Time

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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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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 me or my family and the medical group shall be released from any and all liability arising from such care. 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.

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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/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

x_____ _____
Signature, Witness Date

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MEDICAL HISTORY

Today's Date: _____

Name:_____Birthdate:_____Age: _____

City of Residence:_____Primary Physician: _____

Chief Complaint:_____Pharmacy: _____

Medication allergies: (list drug and reaction)

_____

_____

Are you allergic to Intravenous Contrast (iodine dye)? **Yes** **No**

Past Medical History

Previous or current illnesses: (Check all that apply)

___Arthritis	___Diabetes	___Hyperthyroidism
___Hypertension	___GERD	___Hypothyroidism
___COPD/Emphysema	___Heart Attack	___Stroke
___Coronary Artery Disease	___Coronary Stents	___Hyperlipidemia
___Ulcers	___Congestive Heart Failure	___Hernia (What type_____)

___Cancer (What type_____)

Other (Please specify): _____

Anticoagulant Use:

___None ___Plavix ___Pradaxa ___Aspirin ___Coumadin ___Other _____

Previous Surgeries: (type and year)

_____

_____

Last Mammogram: (Date/Year)_____/_____ Last Colonoscopy: (Date/Year)_____/_____

Social History

Marital Status _____ Occupation _____

Do you drink alcohol? **Yes** **No** If so, how much per day? _____

Have you ever used street or IV drugs? **Yes** **No**

Do you smoke or use tobacco products? **Yes** **No** If so, how much per day? _____

If you quit, when and how much did you use prior to quitting? _____

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Family History: Does anyone in your family have (or have had):

*Check all that apply and specify **who, what kind,** and at **what age**?*

___Heart problems (Please specify): _____

___Blood clotting problems (Please specify): _____

___Cancer (Please specify): _____

___Lung problems (Please specify): _____

___Diabetes: _____

___Bowel disorders (Please specify): _____

System Review: (check all that apply)

General: ___Weight gain ___Recent weight loss ___Fevers ___Fatigue ___Night sweats

Eyes: ___Glaucoma ___Cataracts ___Wear glasses ___Sudden loss of vision

Oropharynx: ___Dentures ___Swallowing problems ___Dental problems

Cardiac: ___Chest pain ___Shortness of breath while sleeping ___Palpitations ___Heart Attack

Respiratory: ___Short of breath ___Productive cough ___Pneumonia ___Bloody cough ___Tuberculosis ___Wheezing

Gastrointestinal: ___Constipation ___Abdominal pain (chronic) ___Blood in stool ___Diarrhea ___Hemorrhoids

Genitourinary: ___Pain with urination ___Frequent nighttime urination ___Urinary incontinence ___Erectile dysfunction ___Kidney stones

Musculoskeletal: ___Muscle weakness ___Broken bones ___Arthritis

Vascular: ___Swelling ___Pain in legs with walking ___Night cramps

Hematologic: ___Bleeding problems ___Blood clots

Lymphatic: ___Blood transfusions ___Swellings in neck/armpits/groins

Integument: ___Skin cancers ___Chronic rashes ___Reaction to tape

Psychiatric: ___Depression ___Mental illness requiring hospitalization

Neurologic: ___Seizures ___Balance problems ___Dizziness ___Strokes ___TIA's

Endocrine: ___Heat intolerance ___Cold intolerance

Breasts: ___Itchy ___Scaliness of the nipple ___Swelling ___Pain ___Nipple discharge

For Nursing Use:

HT_____Weight_____BP_____/_____Pulse_____Respirations _____

HEREDITARY CANCER QUESTIONNAIRE

Personal Information

Patient Name: _____ **Date of Birth:** **Age:** _____
Gender (M/F): _____ **Today's Date(MM/DD/YY):** _____ **Healthcare Provider:** _____
Reason for Today's Visit:

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great-Grandchildren*

YOU and YOUR FAMILY'S Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
DY ON	BREAST CANCER *(Female or Male)*							
DY ON	OVARIAN CANCER *(Peritoneali Fallopian Tube)*							
DY ON	UTERINE {ENDOMETRIAL) CANCER							
DY ON	COLON/RECTAL CANCER							
D Y O N	10 or more LIFETIME COLORECTAL POLYPS *(Specify ti)*							
DY ON	OTHER CANCER{S) *(Specify cancer type)*	Among others, consider the following cancers: *Mekmoma, Pancrecttk:,Stomach (Gastric),Prostate, Brain, Kidney, Bladder,Small bowel, Sarcoma,Tri yrairi*						

D Y D N Are you of Ashkenazi Jewish descent?

DY D N Are you concerned about your personaland/or family history of cancer?

D Y D N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/ include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply}

Personal and/or family history of any one of the following:

D	**Multiple** A combination of cancers on the same side of the family:	D **2 or more:** breast/ ovarian / prostate/ pancreatic cancer 0 **2 or more:** colorectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter / renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) 0 **2 or more:** melanoma / pancreatic
D	**Young** Any 1 of the following at age **SO or younger:**	0 Breast cancer 0 Colorectal cancer D Endometrial cancer
D	**Rare** Any 1 of these rare presentations at **any age:**	0 Ovarian cancer D Breast: Male breast cancer or Triple negative breast cancer D Colorectal cancer with abnormal MSI/IHC, or MSI associated histology [t1] D Endometrial cancer with abnormal MSI/IHC D 10 or more colorectal polyps*

t t Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern • Adenomatous type

Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com

Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: _____ Date: _ _ _ _ _ _ _ _ _ _

Healthcare Provider's Signature: Date:

For Office Use Only: Patient *offered* hereditary cancer genetic testing? D YES D NO D ACCEPTED 0 DECLINED
Follow-up appointment scheduled: DYES D NO Date of Next Appointment:

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Medication List

Preferred Pharmacy_____

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

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Narcotic Pain Medication Policy

Facts:

1) Narcotic pain medication dependence/abuse is second only to marijuana dependence/abuse in the U.S. according to the National Institute of Drug Abuse. The number of people in the U.S. who abuse prescription pain medications is greater even then those who use heroin, cocaine, and other illegal drugs (other than marijuana) combined.

2) Prescribing narcotic pain medications is serious business and irresponsible prescribing by doctors and irresponsible use by patients is not only dangerous to patients and anyone else that may be harmed because of abuse but it is taken very seriously by the U.S. Drug Enforcement Agency and can result in revocation of a doctor's prescribing authority, suspension of clinical privileges, legal action, or even prison.

3) People who require pain medications for more than a week or two should have their primary care provider help them manage their pain over the long term; this may ultimately require a pain specialist evaluation. Long term narcotic use inevitably leads to narcotic dependence. If you don't have a primary care provider and you have issues with pain you should find a primary care provider to help you manage your chronic pain issues.

4) Surgeons treat specific conditions where the best therapy involves an invasive procedure such as removing a diseased organ as in appendicitis or cancer, or repairing an anatomic abnormality as in fixing a hernia. Surgeons are not the best physicians for managing your pain for more than a week or two. Pain is not a surgical disease unless the pain is caused by something that can be treated surgically.

Policy:

1) If you have a primary care provider you should receive your pain medications from them.

2) If you do not have a primary care provider, I will assist you with treating your pain **for no longer than 2 weeks** to give you time to find a primary care provider who should then take over your pain management.

3) If I have performed surgery on you, I will help you with your pain management during the postoperative period but then your primary care provider should take over your pain management for pain that lasts beyond the expected recovery time.

4) **Under no circumstances** will I provide you with a replacement prescription for a narcotic pain medication. A possible sign a patient is potentially abusing a pain medication is when they call asking for a replacement prescription because they lost the prescription or the pain pills, the pills were inadvertently thrown away, the pills fell in the toilet, etc. I realize that accidents happen but I cannot be certain who's legitimately lost their medication and who's abusing it.

x_____ **x**_____

Patient Signature Date / Time