THE CHRIST HOSPITAL PHYSICIANS

Today's Date: ________________

Patient's Legal Name: ____ ______________
Last First Middle Initial Date of Birth

Contacts: In the event you are incapacitated or a minor, we may be required to contact your Healthcare Power of Attorney (POA) or Legal Guardian regarding your health information.* Please list any of the following:

Legal Guardian Name: ______________________________ Phone(   ) ______________

Healthcare POA Name: ______________________________ Phone(   ) ______________

Other Contacts: In the event we are unable to reach you, we are permitted to discuss or release your health information* to the following:

Name: ______________________	Name: ______________________
Relationship to Pt: ______________	Relationship to Pt: ______________
Home #: ( ) ______________	Home #: ( ) ______________
Work #: ( ) ______________	Work #: ( ) ______________
Cell #: ( ) ______________	Cell #: ( ) ______________

*health information includes, but is not limited to, your information regarding test results, prescription refills, billing questions, and in cases of emergency.

May we leave messages/test results on your answer machine? Y N

May we call you at your place of employment? Y N

The following may pick up my written prescriptions for controlled substances:

Name: ______________________	Relationship: ______________________
Name: ______________________	Relationship: ______________________
Name: ______________________	Relationship: ______________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

We are legally required to provide you with a copy of our NOTICE OF PRIVACY PRACTICES the first time you receive care at TCHP. If you are here for emergency medical treatment, you will be given a copy as soon as possible.

- ☐ I have received a copy of the Notice of Privacy Practices.
- ☐ I have previously received a copy of the Notice of Privacy Practices.
- ☐ I do not want a copy of the Notice of Privacy Practices.

AUTHORIZATION OF MEDICAL AND RELATED HOSPITAL SERVICES

1. CONSENT TO TREATMENT: I hereby consent to the administration of medical, nursing or other treatment, drug therapy and/or testing as considered necessary for my condition as directed by The Christ Hospital Physicians or assistants or designated as may be needed. I understand that the Christ Hospital is a teaching hospital and agree that interns, residents, fellows, nurses, medical students and other health personnel in training may participate with or assist my doctor(s) in the performance of medical, surgical or diagnostic procedures/treatment that my doctor(s) consider necessary.

2. RELEASE OF RECORDS: I authorize the release of medical records information (including but not limited to information concerning drug related conditions, alcoholism, psychiatric conditions HIV testing, AIDS diagnosis/related conditions) to insurance carriers, third-party payers or their representatives, and/or review organizations as deemed necessary to determine benefits entitlement and to process payment claims for health services provided. I also understand my records may be related to state, federal or other surveyors for accreditation and/or regulatory licensing purposes. I authorize the release of medical record information to the physician(s) or agency for my follow-up care, and/or to the healthcare facility to which I am transferred from The Christ Hospital. I authorize the Christ Hospital Physicians to access, release, and share accessible electronic medical information with other medical providers who utilize an electronic medical record system compatible with The Christ Hospital Physicians' system. I also authorize release of my medical record information as required or permitted by law.

3. NOTICE: I understand that certain physicians providing services to me, including Radiologists and Pathologists are independent contractors not employed by the hospital, and that I will be billed by the individual physician for services rendered to me by these physicians.

4. FINANCIAL AGREEMENT: I hereby authorize The Christ Hospital to submit a claim to my insurance carrier(s) or its intermediaries to issue payment DIRECTLY to the Christ Hospital on behalf of such rendered services. I understand that I am financially responsible to The Christ Hospital for any balance not covered by my insurance carrier.

5. COMMUNICATING WITH YOU: Consent to contact by electronic and other means. The Christ Hospital Physicians, its employees, its affiliates, and the vendors, agents, contractors, collectors, successors, and assigns of The Christ Hospital Physicians and its affiliates (collectively, "TCHP"), may contact me for any lawful reason, including for the collection of amounts owed to TCHP and for the offering of products or services in compliance with applicable privacy policies and requirements that are in effect from time to time. No such contact will be deemed unsolicited. By signing below, I authorize and voluntarily consent to TCHP contacting me: (i) at any address (including email) or telephone number (including wireless cellular telephone or ported landline telephone number) that I provide, have provided, or that was provided on my behalf to TCHP; (ii) using any means of communication (including but not limited to postal mail, electronic mail, telephone, text, messaging or other technology) to reach me; and (iii) using automated dialing systems and announcing devices and playing recorded messages.

I understand that I may contact The Christ Hospital HIM/Medical Records Department to ask that TCHP not contact me using any one or more methods or technologies by writing to us at 2139 Auburn Avenue, Cincinnati, OH 45219, calling us at 513-263-8660 or by any other reasonable means. I understand that my receipt of healthcare treatment and services is not conditioned upon my agreement to this provision.

____ ____________________

SIGNATURE OF PATIENT (if 18 years or older) OR LEGAL GUARDIAN IF PATIENT IS A MINOR Date/Time

THE CHRIST HOSPITAL PHYSICIANS

PATIENT REGISTRATION INFORMATION R-7230 REV. 07/16 PAGE 1 OF 2

Today's Date: ______________

Patient Information: (please print)

Legal Name: ______________ (Last) ______________ (First) ______________ (Middle Initial)

Social Security Number: ______________ Gender: ______________ Date of Birth: ______________

Maiden Name: ______________ Other Names Used/Nickname: ______________

Address: ______________ (Number) (Street) (City) (State) (Zip)

Home #: (   ) ______________ Work #: (   ) ______________ Cell #: (   ) ______________

Email Address: ______________ Marital Status: S___ M___ D___ W___ Separated___ Partner___

Language Spoken (patient): ______________ Language Spoken (caregiver): ______________

Need Interpreter: Y___ N___

Religion: ______________ PCP Dr.: ______________

Race: White___ African American___ American Indian___ Asian___ Native Alaskan___ Native Hawaiian___ Refused___ Other___

Ethnicity: Non-Hispanic___ Hispanic___

Employment Information: Retired: Y N Retirement Date: ______________

Patient's Employer: ______________ Occupation: ______________

Employer's Address: ______________ (Number) (Street) (City) (State) (Zip)

Insurance Information:

Primary Ins Name/Claims Address:

Policy/ID#: ______________ Group #: ______________ Patient Relationship to Subscriber: Self___ Spouse___ Child___ Other___

Subscriber Info: Name: ______________ DOB: ______________ SSN#: ______________

Employer: ______________ Work #: (   ) ______________ Full time___ Part time___

Address: ______________ (Number) (Street) (City) (State) (Zip)

Secondary Ins Name/Claims Address:

Policy/ID#: ______________ Group #: ______________ Patient Relationship to Subscriber: Self___ Spouse___ Child___ Other___

Subscriber Info: Name: ______________ DOB: ______________ SSN#: ______________

Employer: ______________ Work #: (   ) ______________ Full time___ Part time___

Address: ______________ (Number) (Street) (City) (State) (Zip)

Do you have a Living Will? Y___ N___

Copy given to Primary Care Physician? Y___ N___