Salina Regional Surgical Associates
Salina Regional Health Center

501 S. Santa Fe Ave., Suite 200
Salina, KS 67401
Ph. (785) 452-7245 ~ Fax (785) 452-7246

Jake Breeding, M.D., FACS
Dwane Beckenhauer, M.D.
Justin Klaassen, D.O.

Patient Name:	Patient DOB:

REGISTRATION FORM

Date: _____ Email Address: _____

PATIENT INFORMATION

Patient Name: _____ Age: _____ Sex: _____
First MI Last

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Birth Date: _____ SSN: _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other: _____

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: _____

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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).

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**_____

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Patient Name:	Patient DOB:

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	Phone Number
_____	_____
_____	_____
_____	_____
_____	_____

I was transferred (referred) to Salina Regional Health Center from _____*N/A*_____ facility.
Should this facility contact SRHC, I authorize SRHC to update the referral facility on my condition.
(if left blank, will default to not authorized and SRHC will not update referral facility).

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 re-disclosed and no longer protected by those regulations.

x_____ **x**_____
Date/Time Signature of Patient or Authorized Agent/Representative

_____ _____
Printed name of authorized agent/representative Authorized Agent/Representative 's 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 ACKNOWLEDGMENT

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 Hospital 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 Hospital 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 NEWBORN TREATMENT:** I request, authorize, and empower my physician(s) to make any provision for medical and surgical care for my newborn baby/babies that may be deemed necessary or advisable by my physician(s).

3. **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 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 Hospital 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.

4. **CONSENT TO DISPOSAL OF TISSUE/FLUIDS/SPECIMENS.** I agree that the Hospital may utilize, destroy, or dispose of any tissues, fluids, or specimens taken from me during treatment.

5. **AGREEMENT TO PAY FOR SERVICES:** I agree, whether I sign this as an agent or as the patient, that in consideration of services to be rendered to me, I hereby individually obligate myself to pay the charges of the Hospital in accordance with its regular rates and terms.

6. **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby assign my insurance benefits otherwise payable to me to be paid directly to the Hospital. 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 costs of collection, including but not limited to attorney fees and collection agency fees.

7. **MEDICARE/MEDICAID/INSURANCE BENEFITS:** I authorize the Hospital 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 Hospital for services furnished to 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.

8. **PERSONAL VALUABLES/BELONGINGS:** I have elected/refused (circle one) to place valuables (i.e.,money, jewelry, credit cards, or other articles of unusual value, etc.) into the Hospital's safekeeping during my period of hospitalization. Dentures, glasses, hearing aids, my garments and essential daily necessities are considered personal belongings. I understand that I am, at all times, responsible for the safekeeping of my personal belongings. I understand that the Hospital CANNOT AND WILL NOT accept responsibility for loss of any of my valuables/belongings, if they are lost or misplaced. Patient/Responsible Party initials _____*N/A*_____.

9. **DENTURES:** The Hospital provides denture cups for me if I require them. I will take precautions to be sure my dentures are properly kept and cared for and they will be kept in the denture cup at all times when I am not wearing/using them.

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10. **AUTHORIZATION FOR DISCLOSURES TO REGULATORY OR OVERSIGHT BODIES AND WAIVER OF ACCOUNTING:** I understand that as part of its health care operations, the Hospital 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.

11. **CONTRABAND WEAPONS/DRUGS:** I agree that should the Hospital 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.

12. **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.

13. **USE OF APPLIANCES:** I hereby agree that in using any and all electrical appliances in my room, not owned by or under the control of the Hospital while a patient in the Hospital, I do so at my own risk and hereby absolve the Hospital from any and all responsibility for injuries or property damage which may result from any use of said appliance.

14. **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.

15. **MEDICARE/TRICARE PATIENTS ONLY:** (only for acute care) I have received a copy of "An Important Message from Medicare/Tricare" and understand my rights as described in that document.

16. **PATIENT RIGHTS INFOMATION:** I have reviewed/received "Patient Right and Responsibilities" and understand my rights as described in that document.

17. **NOTICE:** Your health information related to work-related illnesses or injuries or to medical surveillance of the workplace may be disclosed to your employer.

PATIENT/PERSONAL REPRESENTATIVE MUST COMPLETE BY SIGNING OR INITIALING

18. **CONSENT TO DISCLOSE GENERAL INFORMATION (Patient Directory) -- Patient Choices (should I not indicate below, I consent for my name to be included in the patient directory):**

☐ **I want my name included in the patient directory**. I understand that my name, location in the hospital, and general condition may be provided to any person asking about me by name (including phone inquiries), and to members of the clergy (including religious affiliation), my family, individuals involved in my health care, for disaster relief effort, or as required by law.

☐ **I do not want my name included in the patient directory**. I understand mail addressed to me will be returned and any flowers sent to me will not be delivered. Any person asking for me by name, including outside telephone calls will not be forwarded and will be told "there is no one by that name listed in our patient directory"

N/A .
(PATIENT/PERSONAL REPRESENTATIVE INITIAL)

19. **ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES.** I hereby acknowledge that I have received a copy of the Hospital'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_____ _____ **x**_____
Patient/Personal Representative Signature **Relationship to Patient** **Date/Time**

_____ _____
Signature, Witness **Date/Time**

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MEDICAL HISTORY

Today's Date: _____
Name: _____ Birthdate: _____ Age: _____
City of Residence: _____ Primary Physician: _____
Chief Complaint: _____ Pharmacy: _____

Past Medical History

Previous or current illnesses: (Check all that apply)

_____Heart attack	_____COPD/Emphysema	_____Ulcers
_____Congestive Heart Failure	_____Thyroid Problems	_____Hernias
_____High Blood Pressure	_____ Intestinal Disorders	_____Diabetes
_____Strokes	_____Cancer (what type) _____	
_____Lung Problems	Other _____	

Females: Number of Pregnancies _____ Age of first menstrual period _____
Number of live births _____

Previous Surgeries: (type and year)
_____
_____
_____
_____

Medication allergies: (list drug and reaction)
_____
_____
_____

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

Family History

Does anyone in your family have (or have had)

Heart problems _____	Cancer _____	Diabetes _____
Blood clotting problems _____	Lung problems _____	Bowel disorders _____

If so, who and at what age? _____
Heart problems: _____
Blood clotting problems: _____
Cancer: _____
Lung problems: _____
Diabetes: _____
Bowel disorders: _____

Social History

Marital Status _____ Occupation _____
Do you smoke or use tobacco products? _____ If so, how much per day? _____

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

Do you drink alcohol? _____ Have you ever used street or IV drugs? _____

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Patient Name:	Patient DOB:

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: _____ Swallowing problems _____ Dental problems _____Dentures

Cardiac: _____Chest pain _____Shortness of breath while sleeping
_____Palpitations _____Heart Attack

Respiratory: _____Shortness of breath _____Productive cough
_____Pneumonia _____Bloody cough
_____Tuberculosis _____Wheezing

Gastrointestinal: _____Constipation _____Diarrhea
_____Blood in stool _____Abdominal pain (chronic)
_____Hemorrhoids

Genitourinary: _____Pain with urination _____Frequent night time 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 _____ Dizziness
_____ Strokes _____ Balance problems
_____ TIA's

Endocrine: _____ Heat intolerance _____ Cold intolerance

Breasts: _____ Itchy _____ Pain _____ Swelling
_____ Scaliness of the nipple _____ Nipple discharge

For Nursing Use:

HT _____ Weight _____ BP _____ Pulse _____

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Medication List

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