Salina Regional Sports Medicine
Salina Regional Health Center

TIMOTHY HAWKES, D.O.
520 S SANTA FE SUITE 240
PHONE: 785-452-7366
FAX: 785-452-7354

Patient Name: _____ Address: _____
City, State, Zip: _____

Dear [f pt name]:

This letter is to confirm your appointment at Salina Regional Sports Medicine Clinic on _____ at _____.
You will be seeing _____. If you cannot make your appointment, please call our office as soon as possible at
(785)452-7366, so we can schedule a new day and time for you to come in.

Your referring physician's office will be responsible for sending us all of the necessary information we need for your appointment, including, but not limited to:

X-rays Myelograms, CAT Scans, MRI's, Bone Scans, ect., and Medical History Records that are related to your condition.

1. Written authorization required for ALL workers compensation from the workman compensation insurance.

2. If you have any personal records, including additional imaging on a disc or prior surgery information, please bring them with you to your appointment as we will need this information to keep up-to-date on your medical history.

3. Please bring a list of medications that you are presently taking with prescribed dosages (prescription and non-prescription).
IT IS OUR OFFICE POLICY TO ONLY REFILL PRESCRIPTIONS DURING OFFICE HOURS, ALLOW 24-48 HOURS FOR ANY REFILL REQUESTS.

4. Please complete this packet and return to our office as soon as possible.

<u>If you have further questions, please feel free to call our office at (785) 452-7366 for scheduling.</u>

****Special Notice****
All Insurance Plans Accepted

If you have an insurance that requires a special referral from your personal physician, please call your referring physician's office to assure the referral has been done.

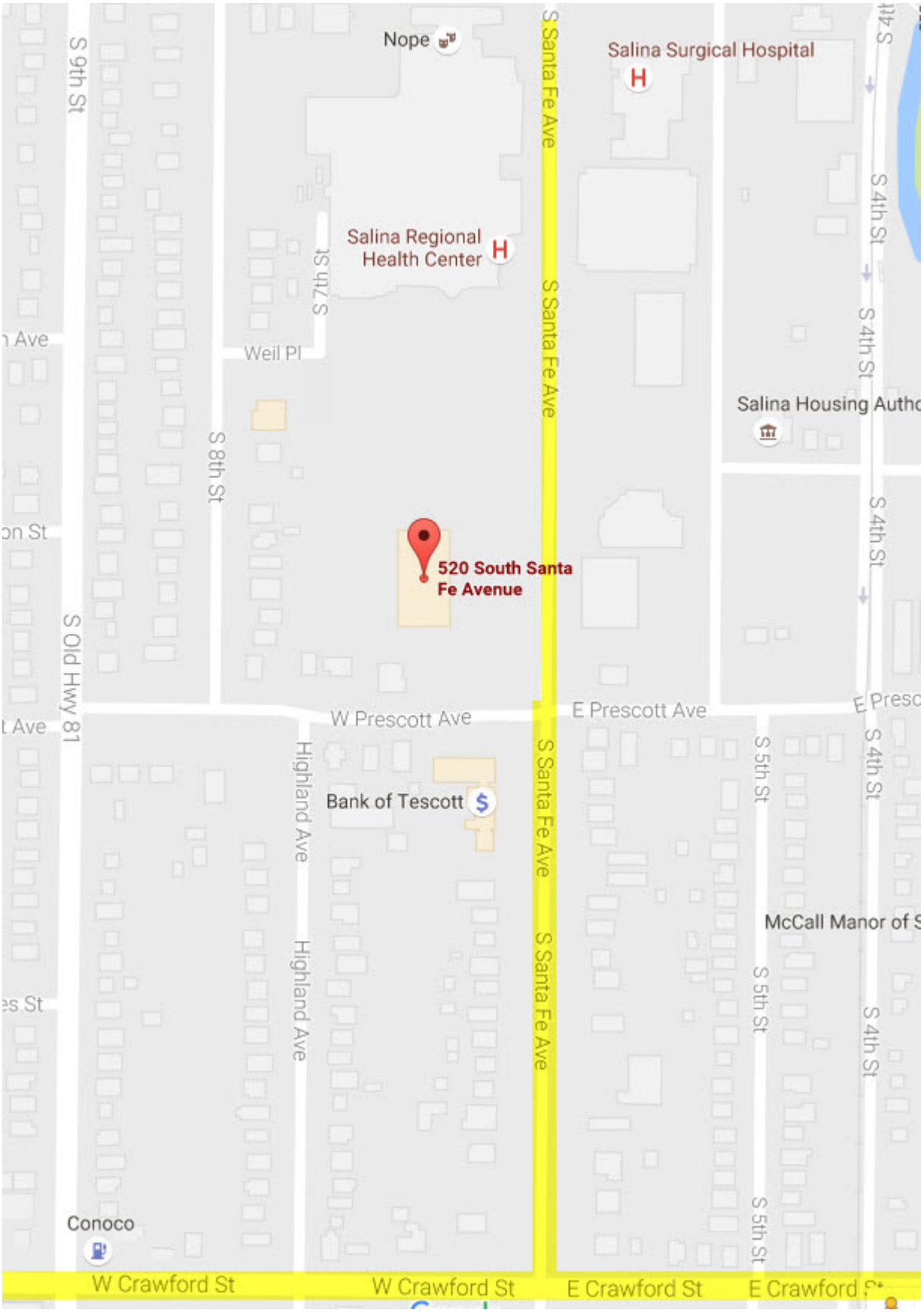
If your insurance contract requires you to pay a COPAY, payment is required upon check in. Also, bring your insurance cards so that we can keep a copy on file and verify the address where to send claims for you.

Please call your insurance carrier (the number should be located on the front or back of your insurance card) to inquire about your coverage and how much you will be expected to pay out of your pocket.

PLEASE ARRIVE 15 MINUTES EARLY.

We appreciate your help.

Thank You


Nope
Salina Surgical Hospital
S 9th St
S Santa Fe Ave
S 4th St
Salina Regional Health Center
S 7th St
Weil Pl
S 8th St
Salina Housing Autho
520 South Santa Fe Avenue
S Old Hwy 81
W Prescott Ave
E Prescott Ave
Highland Ave
Bank of Tescott
S 5th St
McCall Manor of S
Conoco
W Crawford St
E Crawford St

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_____

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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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: _____

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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 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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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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_____

MEDICATION LIST

Preferred Pharmacy:

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

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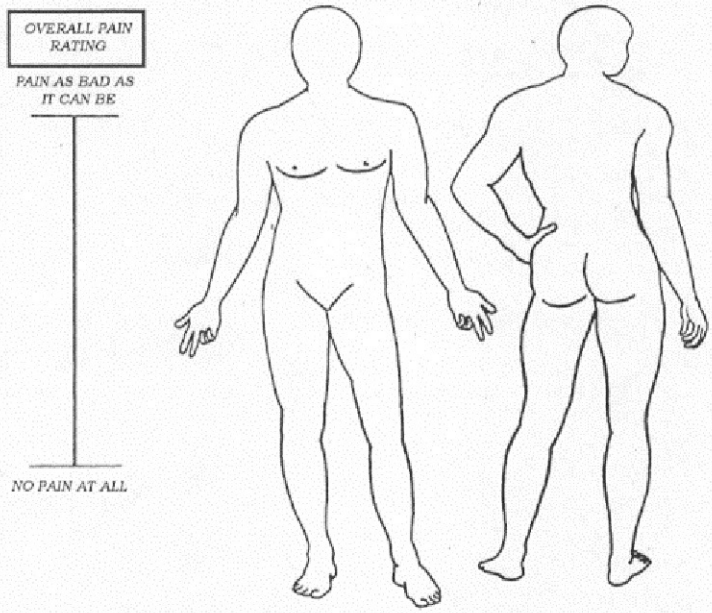
PAIN HISTORY

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**



PAIN INTENSITY (Circle One)

0	1	2	3	4	5	6	7	8	9	10
Normal No Pain	Very Weak	Weak	Moderate		Somewhat Strong	Strong		Very Strong	Very Very Strong	Emergency

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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