SAINT LUKE'S HEALTH SYSTEM PATIENT REGISTRATION SHEET

(Please Print)

Please present your insurance card(s) to the receptionist so we may obtain a copy for billing purposes.

Today's Date: _____ / _____ / _____ **MRN:** _____

PATIENT LAST NAME: _____ FIRST NAME: _____ MI: ____ SSN: _____

NICK NAME: _____ DATE OF BIRTH: ____ / ____ / ____ SEX: MALE / FEMALE

PHONE: _____ CELL: _____ WORK: _____

ETHNIC GROUP: HISPANIC /BLACK /WHITE /OTHER (SPECIFY) _____ RELIGION: _____

MARTIAL STATUS: _____ EDUCATION: _____ LANGUAGE: _____

EMAIL ADRESS: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____ EMPLOYER PHONE: _____ FULL OR PART TIME (circle)

EMERGENCY CONTACT NAME: _____ ADDRESS: _____ PHONE #: _____

REFERRING PHYSICIAN: _____ REFERRING PHYSICIAN PHONE: _____ FAX: _____

PRIMARY CARE PHYSICIAN: _____ PRIMARY PHYSICIAN PHONE: _____ FAX: _____

PREFERRED PHARMACY: _____ PHARMACY PHONE: _____

PHARMACY ADDRESS: _____

- - INSURANCE INFORMATION - -

PRIMARY INSURANCE: _____ GROUP NAME / #: _____ SUBSCRIBER DOB: _____

CERTIFICATE #: _____ SUBSCRIBER NAME: _____

SECONDARY INSURANCE: _____ GROUP NAME / #: _____ SUBSCRIBER DOB: _____

CERTIFICATE #: _____ SUBSCRIBER NAME: _____

- - SPECIAL PERMISSIONS - -

PLEASE INITIAL AND DATE APPLICABLE STATEMENTS BELOW:	INITIAL	DATE
I GIVE PERMISSION TO LEAVE VOICE MAIL OR ANSWERING MACHINE MESSAGES AT MY HOME. THE MESSAGE CAN INCLUDE THE NATURE OF THE CALL, BUT NOT SPECIFIC INFORMATION.		
I GIVE PERMISSION TO CALL ME ON MY CELL PHONE.		
I GIVE PERMISSION TO DISCUSS MY MEDICAL AND DENTAL CARE AND BILLING INFORMATION WITH (Another Individual (s)) _____ AND _____.		
I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES.		
I PREFER TO RECEIVE SAINT LUKE'S HEALTH SYSTEM INFORMATIONAL MAILINGS (circle one) YES NO		

I HAVE REVIEWED THE ABOVE INFORMATION AND, TO THE BEST OF MY KNOWLEDGE, IT IS CORRECT AND COMPLETE.

_____

(SIGNATURE OF PATIENT OR GUARDIAN) **DATE**

ALLERGIES:

(Medications / Anesthesia / Dyes / Tape / Iodine / Latex / Betadine / Food / Other)

Item	Type of Reaction	Item	Type of Reaction

CURRENT MEDICATIONS

(List all prescriptions and over the counter medications, i.e., vitamins, diet aids, herbs, laxatives, inhalers)

NONE ☐

Current Medication	Dose	Schedule	Last Taken	Current Medication	Dose	Schedule	Last Taken

Please list any prior surgeries:

_____

_____

_____

_____

BLADDER SATISFACTION SURVEY

Name_____ Doctor _____

Which symptoms best describe you?

Frequent Urination – Day, Night, or Both

Sudden or Strong Urge to urinate

Leaking with Urge or No Warning
(Unable to make it to the bathroom in time)

Leaking with Sneezing, Coughing, Exercising

Unable to Empty the Bladder

None of These Describe me

How long have you had these symptoms? _____

Have you tried medications to help your symptoms? Yes No

If yes, check the medications you have tried:

Detrol® LA Ditropan XL® Flomax® Cardura®

Oxytrol® Patch Enablex® VESIcare® DDAVP®

Sanctura® Elavil® Elmiron® Other

Did these medications help your symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

No Relief ***Completely Cured***

If you've stopped taking your meds explain why:
Did not Help Side Effects Too Expensive

Describe Side Effects

Behavior Modifications Tried_____
(i.e., caffeine intake, lifestyle changes, bladder training, pelvic floor muscle training)

What is your level of frustration with your bladder symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated **Very Frustrated**

Do you currently have any problems with bowel function?:
Fecal Incontinence Constipation Other

I am interested in learning more about treatment alternatives to medications:
Yes No

Saint Luke's Urogynecology Center for Women

CHECKLIST: Review of Systems

General-

☐ Weight Loss or gain ☐ Fever or Chills ☐ Trouble Sleeping
☐ Fatigue ☐ Weakness

Skin-

☐ Rashes ☐ Itching ☐ Dryness
☐ Hair and nail changes

Head-

☐ Headache ☐ Head injury

Ears-

☐ Decreased hearing ☐ Earache
☐ Ringing in ears (tinnitus) ☐ Drainage

Eyes-

☐ Vision changes ☐ Blurry or double vision ☐ Cataracts
☐ Glasses or contacts ☐ Glaucoma

Nose-

☐ Stuffiness ☐ Itching ☐ Nosebleeds
☐ Discharge ☐ Hay fever ☐ Sinus pain

Breasts-

☐ Lumps ☐ Discharge
☐ Pain ☐ Self-exams

Respiratory-

☐ Cough (dry or wet, productive ☐ Coughing up blood (hemoptysis)
☐ Wheezing ☐ Shortness of breath (dyspnea)

Cardiovascular-

☐ Chest pain or discomfort ☐ Difficulty breathing lying down (orthopnea)
☐ Palpitations ☐ Swelling (edema)
☐ Shortness of breath with activity (dyspnea)

Gastrointestinal-

☐ Heartburn ☐ Rectal bleeding ☐ Constipation
☐ Nausea ☐ Diarrhea

Urinary-

☐ Frequency ☐ Blood in urine (hematuria)
☐ Urgency ☐ Burning or pain ☐ Incontinence

Genital-

☐ Pain with sex ☐ Hot Flashes ☐ Itching or rash
☐ Vaginal dryness ☐ Vaginal discharge ☐ STD's

Vascular-

☐ Calf pain with walking (Claudication) ☐ Leg cramping

Musculoskeletal-

☐ Muscle or joint pain ☐ Back pain ☐ Swelling of joints

Neurologic-

☐ Dizziness ☐ Weakness ☐ Tremor
☐ Fainting ☐ Numbness ☐ Seizures
☐ Tingling

Hemotolgic-

☐ Ease of bruising ☐ Ease of bleeding

Endocrine-

☐ Head or cold intolerance ☐ Frequent urination (polyuria)
☐ Change in appetite (polyphagia) ☐ Thirst (polydypsia)

Psychiatric-

☐ Nervousness ☐ Memory Loss ☐ Stress
☐ Depression

Bladder Health Questionnaire

Please bring this form with you on the day of your appointment

Question	Yes	No
How often do you urinate during the day / evening?		
How often do you get up at night to urinate?		
When did your bladder problems begin?		
Do you usually have a strong sense of urgency to urinate?		
Do you experience pain when your bladder if full?		
Can you postpone emptying your bladder easily?		
Do you lose urine when you are lying down or asleep?		
Do you lose urine when you sneeze, cough, jump, run or laugh?		
Do you lose urine when you get up from a sitting position?		
Do you lose urine when you hear, see or feel running water?		
Do you lose urine when you can't get to the bathroom on time?		
Do you lose urine when you don't even know it?		
Do you wear protection for urinary leakage?		
If yes, do you use panty liners shield type pads, briefs underwear?		
If yes, how many do you wear per day?		
Do you have difficulty starting your urine stream?		
How do you start your urine stream? ☐ Easy ☐ Push Strain ☐ wait less than 1 minute. ☐ wait more than 1 minute		
Do you have pain when emptying your bladder?		
When urinating, can you stop your stream?		
Do you feel you have completely emptied your bladder?		
Do you notice dribbling of urine after emptying your bladder?		
Have you ever had a tube placed in your bladder because you were unable to empty your bladder?		
Have you ever had your urethra dilated or stretched?		

Revised 2011

Bladder Health Questionnaire

Please bring this form with you on the day of your appointment

Question	Yes	No
Have you ever passed blood in your urine?		
Have you ever had a kidney or bladder stone?		
Have you been treated for 3 or more urinary tract infections?		
Have you had an infection within the last 6 months?		
Do you leak gas or stool?		
Are you constipated?		
If you are a female, how many pregnancies have you had? _____Vaginal deliveries _____C-Sections _____Miscarriages		
What treatments for your bladder problems have you tried in the past? ☐ Kegel Exercises ☐ Pessary Insertion ☐ Fluid/Diet Changes ☐ Collagen Injections		

Bladder Diary

This diary is a chart for you to report the amount you drink and the amount you drink and the amount you urinate (empty your bladder). Please complete this form for any 48-hour period prior to your appointment. Use a 2-cup measuring cup (or any other devise) to measure your urine. It can be washed in the dishwasher or discarded. Record the amount and type of fluids you drink and the amount of leakage if you leak urine.

Please bring this form with you on the day of your appointment.

Name: _____

Date	Time	Amount Urinated	Amount of Leakage: D-Drops M-Medium S-Soaked	Activity Only When You Leak	Amount of Fluid Intake and Type of Fluid

Revised 2011

Clinic PHI Form

Saint Luke's Health System

Assignment of Benefit Release

I hereby assign to Saint Luke's Health System (SLHS) my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to SLHS. I understand that I am responsible for satisfying the precertification requirements for any policy of insurance, self-insured health plan or government plan covering services provided by SLHS.

I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for medical services and that I am financially responsible for all charges whether or not they are covered by my insurance.

Signature:_____Date:_____Time:_____
(Signature of Patient or Parent, Legal Guardian or Representative)

AUTHORIZATION TO RELEASE INFORMATION FOR TREATMENT, BILLING, OR HEALTH CARE OPERATIONS

I understand that I have the right to review the Privacy Notification prior to signing this consent. I understand that SLHS reserves the right to change their notice and practices, and I will be given new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations, and the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Records may be needed in order to process a claim for medical services. I authorize SLHS to release information needed for billing purposes to entities that may provide services pertaining to my physician visit, such as reference laboratories. I understand that by signing below, I am authorizing the release of all or any part of my medical record for the purpose of my treatment, billing, or pertinent health care operations. This release may include records containing information regarding the diagnosis and/or treatment of HIV or AIDS, mental illness, and/or drug and/or alcohol addiction or abuse to any person or corporation which is or may be liable under a contract for all or part of the medical charges, including but not limited to, Medicare, Medicaid, or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or patient's employer.

Patient's Printed Name:_____

Patient's Date of Birth:_____

Minor Patient: ☐ Yes ☐ No

Signature:_____Date:_____Time:_____
(Patient or Legal Representative Signature)

Signature:_____Date:_____Time:_____
(Witness)

Patient Label:

SYS-829 (Rev. 05/22/18)

Saint Luke's Health System

Consent and Agreement of Health Care Services

CONSENT FOR TREATMENT I consent to and authorize Saint Luke's Health System's ("SLHS") entities and physicians to provide healthcare services under the general and specific instructions of members of the medical staff. At the discretion of the professional staff, I further consent to any examinations, tests or procedures that may be deemed advisable or necessary in the diagnosis and treatment. I am aware that the practice of medicine is not an exact science. I understand that no promise, guarantee or warranty has been made regarding the results of medical treatment or examination. I authorize the Entity and my physicians to take photographs, or other images, of me or parts of my body to be used in medical evaluations or education. I also authorize the use of video/audio technology (e.g. eICU, eHospitalist, eConsults and other eHealth/telemedicine services) to monitor, assess and interact with me while under the care of the Entity to be used in medical evaluations or education.

PROFESSIONAL CARE The patient is under the professional care of an attending physician who arranges for services in the care and treatment of the patient. I realize that those who provide patient care at this Entity are medical, nursing and other health care personnel in training who may be participating in patient care as part of their education.

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize the release of all or any part of the patients medical and accounting record which may include information relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment of alcohol/drug abuse to any person or corporation which is or may be liable under a contract for all or part of the medical charges. I also authorize the Entity to release information needed for billing purposes to physicians or entities that provide services to me related to my admission to the Entity. I understand that no information that will identify me in any way will be published. I also consent to the sharing of my health information within the Saint Luke's Health System for the purposes of treatment, payment, and healthcare operations. I understand that SLHS participates in various electronic health information exchanges designed to ensure my health information is available to all persons and entities providing me with care, payment for that care, or for other purposes permitted by law. This includes health information exchanges through Midwest Health Connection, Epic's Care Everywhere, and any other health information exchanges that SLHS participates in (collectively, the "Exchanges"). I understand that SLHS may disclose my health information to the Exchanges, and access my health information in the Exchanges, as outlined in this Consent.

ASSIGNMENT OF BENEFITS I hereby assign to Saint Luke's Health System's entities and any or all physicians; all of my interest and right to the insurance benefits otherwise payable to me for this hospitalization or outpatient services arising out of any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or on my behalf. I further authorize payment of hospital benefits (including major medical) directly to the hospital, which provided care. I assign payment of physician benefits (including major medical) to the physician or organization furnishing the services or authorize such physician or organization to submit a claim for payment. I understand that I am responsible for satisfying the precertification requirements for any policy of insurance, self-insured health plan or government plan covering said hospitalization or outpatient service and that the Entity is not responsible for precertification. I further understand that I am financially responsible for any penalties imposed by the insurance company or self-insured health plan for lack of precertification and/or any charges not covered by this assignment of benefits.

AUTHORIZATION TO FILE AN APPEAL ON PATIENT'S BEHALF I understand at times the level of care or medical necessity for services determined appropriate by my physician may differ from the opinion of my insurance company and they may deny payment of a portion of my Entity billing. To assist me in resolving this dispute, I authorize the Entity to act on my behalf to file a grievance or appeal of such denial by my insurance company in accordance with applicable law and to notify the Entity directly of the determination of such grievances or appeals.

FINANCIAL RESPONSIBILITY In consideration of the Entity and the physicians supplying or furnishing hospitalization, Entity services and physician services; I promise to pay the Entity and the physicians for such hospitalization, Entity services and physician services supplied and furnished heretofore or to be supplied and furnished to said patient. I understand that the acceptance of insurance assignments does not relieve me from any responsibility concerning payment for said services and that I am financially responsible to the Entity and physicians for the charges not covered by the policy of the insurance or self-insured health plan. I also understand, pursuant to the hospital lien statutes of this state, if my injuries were caused by the negligence or wrongful act of another, Saint Luke's Health System may have a lien on any and all claims or rights of action I may have against the person causing my injuries, and Saint Luke's Health System may have the right to enforce the lien for payment of services rendered rather than seek payment from my insurance or self-insured health plan. In the event of collection, the cost of collection, including reasonable attorney fees and court costs shall be included as part of the obligation due Saint Luke's Health System's entities and physicians. Any correspondence or payments regarding disputed debts, or any payments that purport to be payments in full satisfaction of the debt owed, must be sent to Saint Luke's Health System Centralized Business Office at 901 E. 104th St., Kansas City, MO 64131.

FINANCIAL ASSISTANCE The hospital has a financial assistance policy for which you may qualify. The income guidelines are based on Federal Poverty Limits. If your income is less than the guideline for your family size, you may qualify for assistance.

PATIENT ASSISTANCE PROGRAMS: In some cases, SLHS may be able to obtain reimbursement for some of your medications and/or medical devices from companies that manufacture them. In the event this occurs, the charge for the medication or medical device is removed from your bill for that hospital stay. Your signature on this form gives SLHS, or agent acting on SLHS's behalf, permission to sign your name on the application if needed, and view and release any personal, medical, and/or financial information required by the Patient Assistance Programs in order to apply for free drug. This information will remain confidential within the SLHS and will be given to the drug manufacturing companies sponsoring the program.

Patient Label:

Saint Luke's Health System

Consent and Agreement of Health Care Services

GENERAL TERMS

Behavior Expectation: I agree that it is my responsibility to treat other patients, visitors, and staff with respect. I agree not to electronically record any direct patient care, or use my phone, tablet or device in a way that interferes with patient care. I understand that disrespectful behaviors will not be tolerated and may lead to evaluation for my discharge.

Consent to Contact: I consent to receive communications from SLHS, its contractors and collection representatives. I may be contacted about an appointment, follow-up reminder, assignment of benefits and/or financial responsibility. Contacts may be via live agent, voicemail, prerecorded or artificial voice messages, text message, automatic telephone dialing system, e-mail, communication apps or other communication technology, to any phone, e-mail address or other contact information or means I have provided. I understand depending on my phone plan I may be charged for calls or text messages. I understand my consent to receive such calls or texts is not a condition of receiving healthcare services.

Exit agreement: I have been informed and agree that I will voluntarily exit from Saint Luke's Health System when it is determined in the medical judgment of my physician or the Hospital's Utilization Review Committee that I no longer need to remain under care.

Release of responsibility for valuables: I understand the Hospital strongly recommends that all personal belongings and valuables be sent home or placed in the hospital's security for safekeeping until discharge. I understand the Hospital shall not be liable for loss or damage to any personal property I may choose to keep with me and will not replace any personal items if they are lost or stolen.

Tobacco free policy: I understand that all Saint Luke's Health System campuses are tobacco free. I acknowledge that I may not smoke or use any tobacco products anywhere on the campus, including the parking lot or grounds of the facility. If I make the decision to go off campus to smoke or use tobacco products, I take full responsibility for my own safety. I agree not to hold the Entity or any of its employees or agents responsible if I am injured in any way because of my decision to smoke or use tobacco products. Minors will follow state and Federal laws regarding smoking. This tobacco free policy applies to e-cigarettes, vaping products and other alternative tobacco and nicotine products.

Patient satisfaction survey: Saint Luke's Health System may contact you regarding the care you received and use this information to improve the quality of care we deliver. This survey may be provided via a telephone call or by email with a link to a secure website where you may provide anonymous input. You may also receive an email from MySaintLuke's inviting you to enroll in our online patient portal, where you can securely communicate with your physician, get lab results, visit summaries, and more.

Coordination of Benefits: I certify the insurance information provided to the Saint Luke's Health System is correct. There is no additional insurance coverage that has not been provided.

I also agree I have received or have been offered information on the topics listed below (as applicable) through signs, packets and/or brochures, which contain information about:

- Advanced Directives
- Patient Advocacy/Patient Rights/Grievance Procedure information
- Financial Assistance policy (FAP) Summary
- Notice of Privacy Practices
- Interpreter services
- Skilled Nursing Welcome Letter and Grievance Procedure

I/We hereby certify that I/we have read all parts of this Consent and Agreement and accept all terms and conditions and state that all representations made by me are true.

☐ Interpretation services utilized

_____

Print Name of Patient

_____

Signature of Patient or Authorized Representative (include Relationship to patient) Date Time

If patient is unable to sign, explain: ☐ Minor ☐ Critical nature of illness ☐ Other:_____

If the patient is unable to sign and there is no Authorized Representative available OR if consent is being obtained via telephone, two witnesses are required.

_____ _____

Signature of Witness 1 Date/Time Print Witness 1 Name

_____ _____

Signature of Witness 2 Date/Time Print Witness 2 Name

Patient Label: