LAKE HEALTH PHYSICIAN GROUP
REGISTRATION

NAME:_____

DOB:_____

Date:	Primary Care Physician:

PATIENT

First Name	Middle Initial	Last Name

SSN	Race _____	☐ Single ☐ Married ☐ Divorced
Sex ☐ male ☐ female	Ethnicity ☐ Non Hispanic ☐ Hispanic	☐ Separated ☐ Widowed
	Language _____	

Date of Birth	Employer	Employer Telephone

Patient Mailing Address

Street Address	City	State	Zip

Primary Telephone Number	Alternate Telephone Number

RESPONSIBLE PARTY (Other Than Self)

First Name	Middle Initial	Last Name

SSN	Relationship to Patient	Sex ☐ male ☐ female

Date of Birth	Employer	☐ Full-time ☐ Part-time	Employer Telephone

Responsible Party Mailing Address (if different from patient)

Street Address	City	State	Zip

Primary Telephone Number	Alternate Telephone Number

EMERGENCY CONTACT

Name	Relationship to Patient

Primary Telephone Number	Alternate Telephone Number

For Office Use Only:

☐ Entered

Initials _____ Date _____

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0816-3117-PG

Lake Health
Physician Group

PATIENT NAME_____

DOB:_____

REQUIRED

FINANCIAL POLICY

In order to provide your health care at the most affordable cost, Lake Health Physician Group requires payment at the time of service.

IF YOU HAVE INSURANCE

Lake Health Physician Group participates with many health insurance carriers. As a service to our patients, we will submit an insurance claim provided we have that information on file. It is the patient's responsibility to ensure that Lake Health Physician Group has the most up-to-date, correct insurance information on file. If you have a copayment, this will be collected when you arrive for your appointment. In the event your health plan determines a service to be "non-covered", you will be responsible for the complete charge. A statement will be sent to you and payment is due upon receipt of that statement.
In the event we are not able to confirm eligibility of your insurance, your visit will be considered self-pay, please see below.

If Lake Health Physician Group does not have a participating agreement with your carrier or you have not provided the most up-to-date insurance information to Lake Health Physician Group, your visit will be considered self-pay. Please see below.

SELF-PAY

If you are without health insurance, we do offer a 35% discount off all services rendered in the Lake Health Physician Group office (does not include any charges for lab and/or radiology professional services by non-employed physicians) when payment in full is made on the service date. Information of the total charges for your visit is available upon check-out. If you are not able to pay for services the same day, a minimum of $150.00 is required per office visit, with the balance remaining due upon receipt of the first statement within 30 days. Failure to pay the outstanding balance could result in no further appointments being scheduled and/or dismissal from Lake Health Physician Group for non-payment in accordance with Lake Health Physician Group's policies.

COLLECTIONS POLICY

If any balance remains on your account; we will consider an outside collection agency or other means to pursue payment of your account. To avoid this, please contact our business office to discuss payment arrangements.

You may also be eligible for financial assistance under Lake Health Physician Group's current financial assistance programs. For more information on Lake Health Physician Group's financial assistance policies, please call 440-602-6682 or visit www.lakehealth.org/patients/financial-information/financial-aid-application for more information.

PATIENT _____ **GUARANTOR** _____

DATE _____ **WITNESS** _____

LAKE HEALTH PHYSICIAN GROUP
OUTPATIENT CONSENT FORM – COMMUNICATION

Name:_____
DOB:_____

Patient Name: _____

Date of Birth: _____/_____/_____ Today's Date: _____/_____/_____

PRESCRIPTION HISTORY CONSENT

I authorize Lake Health Physician Group to obtain my prescription history from an external source.

X _____ Date: _____ Time: _____
Patient or Legal Guardian Signature

CONSENT FOR COMMUNICATION REGARDING MY HEALTH (Adult Patients Only)

I hereby authorize Lake Health/Lake Health Physician Group to discuss protected health information with a family member, guardian or friend listed below. This includes information related to the care or changes to the care that I have received. ***This does not authorize requests for copies of medical records. An "Authorization for Disclosure of Health Information" must be completed when requesting copies of medical records.***

1. Name: _____ Relationship: _____
   Phone Number: _____
2. Name: _____ Relationship: _____
   Phone Number: _____

CONSENT FOR COMMUNICATION REGARDING A MINOR (Pediatric Patients Only)

This consent authorizes Lake Health/Lake Health Physician Group to discuss protected health information with a family member, guardian or friend listed below. This includes information related to the care or changes to the care that a minor has received. ***This does not authorize requests for copies of medical records. An "Authorization for Disclosure of Health Information" must be completed when requesting copies of medical records.***

1. Name: _____ Relationship: _____
   Phone Number: _____
2. Name: _____ Relationship: _____
   Phone Number: _____

THE FOLLOWING INDIVIDUAL(S) MAY BRING MY CHILD IN FOR TREATMENT IN MY ABSENCE
Note: This Authorization Does NOT Grant Access to Medical Records.

1. Name: _____ Relationship: _____
   Phone Number: _____
2. Name: _____ Relationship: _____
   Phone Number: _____

MINORS (16-18 YEARS) PRESENTING WITHOUT A PARENT OR GUARDIAN

☐ I give permission to Lake Health/Lake Health Physician Group to provide medical care to my child (examinations, immunizations, laboratory tests, radiology tests, prescribe medications).

☐ I do not give permission to Lake Health/Lake Health Physician Group to provide medical care to my child (examinations, immunizations, laboratory tests, radiology tests, prescribe medications).

Name:_____
DOB:_____

CONSENT FOR TELEPHONE, EMAIL, AND/OR TEXT MESSAGE COMMUNICATIONS

I hereby authorize Lake Health/Lake Health Physician Group to communicate the following protected health information contained in my medical record with me via the following forms of communication (check where applicable):

☐ Home Phone (_____) _____ - _____
- ☐ I consent to receiving information at this number via voicemail.
- ☐ I consent to receiving information at this number via text message.

☐ Work Phone (_____) _____ - _____
- ☐ I consent to receiving information at this number via voicemail.
- ☐ I consent to receiving information at this number via text message.

☐ Cell Phone (_____) _____ - _____
- ☐ I consent to receiving information at this number via voicemail.
- ☐ I consent to receiving information at this number via text message.

☐ E-mail _____ @ _____

I understand that voicemail, e-mail, and text messages are not a confidential method of communication. I further understand that there is a risk that voicemail, e-mail, and text communications between myself and Lake Health/Lake Health Physician Group regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I understand that Lake Health/Lake Health Physician Group is not responsible for e-mail or text messages that are lost due to technical failure during composition, transmission, and/or storage. I also understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail or text messaging.

This authorization shall be in force and effect for twelve (12) months from the date of signature. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may no longer be protected by federal or state law.

THESE CONSENTS AND AUTHORIZATIONS ARE VALID FOR TWELVE (12) MONTHS FROM THE DATE OF SIGNATURE BUT MAY BE REVOKED BY NOTIFYING LAKE HEALTH IN WRITING AT ANY TIME. I UNDERSTAND THE NATURE OF THIS CONSENT AND IT IS REVOCABLE AT ANY TIME.

Patient/Legal Guardian Signature: _____ Date: _____ Time: _____

Relationship: _____

Witness Signature: _____

An employee of Lake Health may witness this consent; however, the employee is signing this Form as a witness and not as an employee or on behalf of Lake Health.

FOR OFFICE USE ONLY	
☐ Entered	
_____	_____
Initials	Date

LAKE HEALTH
PATIENT CONSENT FORM Page 1 of 2

Name:_____
DOB:_____

REQUEST FOR GENERAL TREATMENT

I request and authorize Lake Health, its employees, my physician and other physicians or allied health professionals as are necessary to provide emergency, outpatient and/or general hospital treatment and care. Further, I authorize the hospital and my physician(s) to permit the presence of observers in my treatment as deemed necessary.

I, _____, understand and acknowledge that from time to time, medical
(Patient Name)
students, nursing students or students of other healthcare disciplines may be undergoing clinical education in various departments at the hospital. I hereby authorize and permit such students of any such health profession to participate in my care insofar as they are properly supervised at all times by a licensed and credentialed healthcare practitioner in that field of expertise. I acknowledge that I have a right to ask questions of any physician or nurse regarding the use of students in my care at any time.

I also understand that some physicians and healthcare providers, including, but not limited to anesthesia, pathology, radiology, surgery, and emergency department providers are independent practitioners ("Independent Practitioners") and are not employees or agents of Lake Health. They are independent contractors acting as my (patient's) agent. Lake Health is not responsible for the acts or omissions of such Independent Practitioners.

Patient Best Contact Number: _____ X (Signature) _____

NOTICE OF INCREASED EXPOSURE TO COVID-19

I understand that during the ongoing COVID-19 pandemic, traveling to Lake Health facilities will increase my possible exposure to COVID-19. I will follow all standard safety precautions required by Lake Health and the State of Ohio when traveling to Lake Health for any treatment. I authorize Lake Health to follow standard precautions to protect myself, Lake Health staff, and other patients including taking my temperature upon arrival and asking me questions to assess my health. If I am experiencing any of the following symptoms I may be asked to reschedule my appointment: fever, shortness of breath, loss of sense of taste or smell, dry cough, runny nose, or sore throat.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Lake Health, Anesthesia Associates, Community Hospitalists, Inc., Drs. Hill & Thomas, Drs. Hill & Chapnick, EKG Associates, US Acute Care Solutions, and other interpreting physicians involved in my care to release any medical records or medical information necessary to file an insurance claim, to perform quality and utilization assessments, and to release any medical information which may be requested by my insurance carrier or agencies on their behalf. I authorize the release to other health organizations and/or professionals such medical information deemed necessary to ensure continuity and quality of care to my routine health care provider (Primary Care Physician) or in the event of my transfer to another institution. Further, I authorize release of medical information to a quality assurance of peer review committee or organization, compliance audits, research, marketing, Department of Health, federal and/or state agencies.

ELECTRONIC COMMUNICATIONS

I understand that Lake Health may utilize, or make available to the healthcare professionals involved in my care, various technologies that are secure, confidential, and meet federal and state privacy and security requirements to allow providers involved in my care to communicate with each other and facilitate clinical decision-making regarding my care. Examples include, but are not limited to: secured texting, taking and sending photographs via secure technology, and other electronic communications.

ASSIGNMENT OF BENEFITS

In consideration of medical services to be received for this admission, I assign to Lake Health or any Hospital-Based Physician, as applicable, all, including Title XVIII of Social Security Administration, other benefits herein specified. This assignment shall be irrevocable.

GUARANTEE OF ACCOUNT

I guarantee payment of any and all hospital or Independent Practitioner charges not covered by insurance of this assignment, including court costs, if appropriate.

AUTHORIZATION TO BE INCLUDED IN DIRECTORY

Lake Health maintains a directory of individuals in its facility that includes the individual's: 1) name; 2) location at Lake Health's facility; 3) condition, which is described in general terms and does not communicate any specific medical information about the individual; and 4) religious affiliation. This information may be provided to members of the clergy or, except for religious affiliation, to any person who asks for the me by name. I wish to have my information listed in the directory. ☐Yes ☐No

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Name:_____

DOB:_____

AUTHORIZATION TO BE CONTACTED FOR FUND RAISING

From time to time, Lake Health may use certain information (e.g., patient ID, name, address, telephone number, dates of service, age, and gender) to contact you to raise funds for the benefit of Lake Health's charitable mission. I wish to receive fundraising communications in the future. ☐ Yes (I understand that I may opt-out of fundraising communications at any time.) ☐ No

YOUR CONSENT FOR CALLS AND / OR TEXT MESSAGES TO YOUR CELLULAR PHONE

I expressly consent to you using my cellular phone number for you, your affiliates or any third party acting on your behalf including collection agencies, calls or text messages, for collection purposes or other account related purposes. Further, I expressly consent to receiving phone calls made by an auto dialer and/or any automatic telephone dialing system from you, your affiliates or any third party acting on your behalf, including collection agencies, telephone calls for collection purposes or for other account related purposes to any cell phone number obtained from me, from any other source, or as a result of a receiving a cellular phone call from me. ☐ Yes ☐ No

ACKNOWLEDGEMENT OF RECEIPT OF MEDICARE/CHAMPUS INFORMATION

I acknowledge that if I am a Medicare and/or CHAMPUS beneficiary, I have been provided with a notice from Medicare and/or CHAMPUS, regarding my rights as a Medicare and/or CHAMPUS hospital patient.

PATIENT RIGHTS

I acknowledge that I have received a copy of "Patients Rights and Responsibilities." ☐ Yes ☐ No

PATIENT PRIVACY

I acknowledge that I have received a copy of "The Notice of Privacy Practices." ☐ Yes ☐ No

PERSONAL CHOICES

I have an Advance Directive - Living Will	☐ Yes	☐ No
I have a Durable Power of Attorney for Health Care	☐ Yes	☐ No
I am an Organ Donor	☐ Yes	☐ No
I wish to receive information about other Lake Health programs	☐ Yes	☐ No
I wish to be included in the clergy census	☐ Yes	☐ No

OBSTETRICS

This consent covers this visit/admission and any subsequent visit/admission relating to this pregnancy.

SERIES

This consent covers this visit and any subsequent visit related to this encounter.

NON-COVERED SERVICES OR EQUIPMENT

Check Insurance Type: ☐ Medicare ☐ Kaiser ☐ Other _____

I understand that the service(s) or equipment checked below are considered to be non-covered by my insurance carrier including Medicare. Because this service/equipment is non-covered, I realize that I will be personally responsible for payment.

Check appropriate service:

☐ Cardiac Rehab Phase III
☐ Pulmonary Rehab Phase III
☐ Durable Medical Equipment
☐ Mammograms (beyond limitations of coverage)

PATIENT BELONGINGS

Patients are responsible for all money and valuables during their Lake Health admission or outpatient visit. Lake Health is not responsible and accepts no liability for lost, misplaced, stolen or retained belongings including but not limited to money, jewelry, dentures, hearing aids, eye glasses, or other prosthetic devices.

I HAVE REVIEWED AND CONSENT TO ALL APPLICABLE CLAUSES BY SIGNING BELOW. I UNDERSTAND THE NATURE OF THIS CONSENT AND IT IS REVOCABLE AT ANY TIME.

Signature X _____ Relationship to Patient: _____

Witness to the above signature: _____ Date: ____/____/____ Time: _____

An employee of Lake Health may witness this consent; however, the employee is signing this Form as a witness and not as an employee or on behalf of Lake Health.

Grievance Process: Should you experience dissatisfaction with your care or services while you are a patient you may call (440) 953-6265 or ext. 6265 to report your concerns. You will be contacted and followup on your concerns will occur.

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