

WISCONSIN HEALTH CENTER PATIENT REGISTRATION

Please print and complete all information requested on this form.

REFERRING PHYSICIAN _____ PHONE # _____

PATIENT – This section refers to PATIENT ONLY

Name _____ Age _____ Date of Birth _____

SS No. _____ Sex (Circle one) Male Female

Marital Status (Circle one) Single Married Divorced Widowed Maiden Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Employer _____ Retired? (Date) _____

Employer's Address _____

City _____ State _____ Zip _____

The State of Wisconsin Office of Health Care Information requires Wisconsin Health Center to provide them with information as to our patient's race and ethnicity. Please check the appropriate areas below.

Race: _____ American Indian or Alaskan Native _____ Asian or Pacific Islander _____ Black _____ White
_____ Other _____ Unknown or do not choose to answer

Ethnicity: _____ Hispanic _____ Not of Hispanic Origin _____ Unknown or do not choose to answer

RESPONSIBLE PARTY – This section refers to PERSON RESPONSIBLE FOR PAYMENT

Name _____ Relationship to Patient _____

SS No. _____ Home Phone _____ Work Phone _____

Employer _____

City _____ State _____ Zip _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____ Relationship to Patient _____

Address _____ Phone _____

PRIMARY INSURANCE INFORMATION OR WORKMAN'S COMP

Insurance Company's Name _____

Insurance Company's Address _____ Date of injury _____

Insured's Name _____ DOB: _____ Relationship to patient _____

Insured's ID No./SS No. _____ Group No. _____

If insured through employer list employer's name here _____

Effective date of insurance coverage _____

SECONDARY INSURANCE INFORMATION

Insurance Company's Name _____

Insurance Company's Address _____

Insured's Name _____ DOB: _____ Relationship to patient _____

Insured's ID No./SS No. _____ Group No. _____

If insured through employer list employer's name here _____

Effective date of insurance coverage _____

I hereby authorize Wisconsin Health Center, LLC to furnish my insurance carrier all information that my insurance company may request concerning my illness or injury. I hereby assign to Wisconsin Health Center, LLC all money to which I am entitled to for medical and surgical expense rendered to myself or dependent. I understand that I am responsible for any amount not covered by insurance. Any bills coming from Wisconsin Health Center are the facility charges and do not pertain to my Physician charges.

PATIENT OR GUARANTOR'S SIGNATURE _____ DATE _____

Beneficiary Name _____

Medicare # _____

I request that payment of authorized Medicare benefits be made on my behalf to Wisconsin Health Center for any services furnished by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Furthermore, this authorization serves this provider to obtain benefits from my Medicare supplemental insurer as indicated below.

Medicare Supplement _____

This authorization is in effect until I choose to revoke it.

Signature _____ Date _____

Revised 9/03

Wisconsin Health Center
Patient History

Patient Name: _____ DOB: _____

Reason for visit: _____

Check (√) conditions you currently have or have had in the past.

Do you have or have you had a history of:

- AIDS/ HIV positive
- Alcoholism
- Anemia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Bronchitis
- Cancer What kind? _____
- Chemical Dependency
- Depression
- Diabetes
- Emphysema
- Epilepsy/ Seizures
- Fainting
- Glaucoma/ Cataracts
- Gout
- Hepatitis What kind? _____
- Herpes What kind? _____
- High Cholesterol
- Kidney Disease
- Liver Disease
- Malignant Hyperthermia/Family H/O Malignant Hyperthermia
- Migraine Headaches
- Multiple Sclerosis
- Pacemaker/ ICD (defibrillator)
- Pain/ numbness/tingling
- Prostate Problems
- Psychiatric Care
- Sinus Problems
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers

- Venereal Diseases
- Other: _____
- _____
- _____

CARDIOVASCULAR

- CABG
- Chest Pain
- Heart Attack
- Heart Disease
- High Blood Pressure
- Irregular ♥ beat
- Low Blood Pressure
- Murmur
- Poor circulation
- Rapid Heart Rate
- Swelling of ankles

GASTROINTESTINAL

- Abd. Pain
- Bloating
- Bowel Changes
- Constipation
- Diarrhea
- Gas
- GERD
- IBS, Crohns, Colitis
- Indigestion
- Nausea
- Rectal Bleeding
- Vomiting/vomiting blood

GYN

- Abnormal Pap Smear
- Bleeding between periods
- Breast Lump

- Extreme menstrual pain
- Hot Flashes
- Nipple Discharge
- Vaginal Discharge

Date of last menstrual period _____

Are you pregnant? _____

Number of Children _____

Any pregnancy complications? _____

ALLERGIES:

SUBSTANCE USE:

- Caffeine How much? _____
- Tobacco How much? _____
- Street drugs How much? _____
- Which kinds? _____
- Other: _____

Have you every had a blood transfusion? _____

What year? _____

WISCONSIN HEALTH CENTER, LLC

Credit Policy

Your physician has chosen to perform your procedure at Wisconsin Health Center which is an Ambulatory Surgical Center. **All procedures performed here will have a Facility and Physician charge that are incurred. In the event that you require an anesthesiologist, there will be separate charges for them in addition to ours, and your physicians.**

Many patients are covered by health insurance contracts, which provide for reimbursement for specific medical fees. If you are not familiar with your policy, it is suggested that you discuss coverage with your carrier before charges are incurred. All insurance policies are contracts between you and your insurance carrier. Your facility bill is an agreement between you and your facility. Our fees may be more or less than the payment schedule of any insurance companies' arbitrary determination of Usual & Customary. **Our facility is a "Preferred Providers" for certain HMO's and PPO's and the contracts that we have signed with these specific carriers supersede our Usual & Customary policy. For our patients who are subscribers to these insurance plans, you will not be billed for amounts above our negotiated fee schedule, with the exception of co-pays, co-insurances and deductibles amounts as stated per your contract.**

You will receive a statement each month for any unpaid balances. Balances due are payable within 60 days of your first statement. We will charge a \$25.00 fee for all returned checks. In the event that your account is forwarded onto our collection agency, you will be responsible for their fees associated with us having to submit your account to collections. We accept MASTERCARD/VISA.

Wisconsin Health Center accepts Medicare Assignment. We will submit insurance claims for you as a courtesy, but it remains the patient's responsibility to make sure your claims are paid. Wisconsin Health Center does not handle any referral processes for your procedures.

Extended payment plans can be arranged through our billing office. These plans are based upon financial circumstances of each patient.

I, the undersigned, have read and understand the above Credit Policy.

Signature Insured/Authorized Person

Date

Patients Name, Print

**Wisconsin Health Center, LLC
Ambulatory Surgical Center**

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosure of personal health information. (PHI) The individual is also provided the right to request confidential communications or that if communications of PHI be made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Home Telephone _____
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication
<input type="checkbox"/> O.K. to mail to my home address
<input type="checkbox"/> O.K. to mail to my work/office address
<input type="checkbox"/> O.K. to fax to this number |
| <input type="checkbox"/> Work Telephone _____
<input type="checkbox"/> O.K. to leave message with detailed information | <input type="checkbox"/> Other _____ |

I hereby give Wisconsin Health Center staff permission to discuss my medical care, lab results, billing, and medication, with the following individuals:

- Spouse _____
- Son/Daughter _____
- Other _____

ACKNOWLEDGEMENT:

I acknowledge that I have received a copy or reviewed the Privacy Practices for Wisconsin Health Center.

*If at any time you would like this permission revoked, you will need to contact Wisconsin Health Center.

Patient Signature/Representative

Date

Print Name/Relationship

Birth Date