KCHC
A Limestone Medical Center Clinic

PATIENT REGISTRATION FORM

HOW DID YOU HEAR ABOUT KCHC? FRIEND/FAMILY ADVERTISING REFERRAL OTHER?

Patient Information

Name_____

Address_____

City_____State_____Zip_____

Spouse/Parent/Guardian Information (Circle One)

Name_____

Address_____

City_____State_____Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Date of Birth_____ Age_____ Patient's Social Security Number _____

Patient's Employer_____

Employer's Address_____

City_____ State_____ Zip_____

Primary Insurance

Insurance Company's Name_____Insured's Name_____

Relationship to Patient (Circle One) Self Spouse Parent Guardian Insured's Date of Birth_____

Insured's Employer_____

Employer's Address_____

Member ID #_____Group Number_____

Secondary Insurance

Insurance Company's Name_____ Insured's Name_____

Member of Insured's Name_____

Relationship to Patient (Circle One) Self Spouse Parent Guardian

Insured's Employer_____

Employer's Address_____

Member ID #_____Group Number_____

In Case of Emergency Contact:

_____Relationship_____ Phone_____

I hereby consent to treatment by the physicians Kosse Community Health Clinic. I authorize release of my medical information to my insurance carrier, governmental agency or its intermediary, any information needed for this or any related insurance claim. If correct information is not provided at the time of service and my insurance carrier denies payment as a result, I understand I am responsible for the full payment of denied claim.

Signature of patient/parent or legal guardian_____ Date_____

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Kosse Community Health Clinic Date_____

PATIENT MEDICAL HISTORY

Patient Name (Last-First-Middle Initial)_____

Preferred Pharmacy_____

Allergies

□ None/No known allergies	□ Adhesive Tape	□ Anesthesia	□ Aspirin	□ Codeine
□ Dairy Products	□ Iodine/Shellfish/Contrast Dye	□ Latex	□ Morphine	□ Penicillin
□ Sulfa Drugs	□ Wheat			

Family History-Indicate if any of your immediate relatives have had any of the following by place an X in the appropriate box.

	Mother	Father	Sibling (Brother/Sister)
Anesthesia Problems			
Arthritis			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			

Social History

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated

Occupation: _____ □ Retired □ Disabled (reason _____)

Do you drink alcohol? □ Yes □ No □ Daily □ Weekly □ Infrequently □ Recovering Alcoholic

Do you use tobacco? □ Yes □ No □ Smoke (_____ packs per day) □ Chew

Surgical History – Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

Type of Surgery	Year or Date	Doctor	Location

Medical History – Have you ever had any of the following?

□ None of the problems listed	□ chest pain	□ hyperlipidemia	□ organ injury
□ allergies	□ CHF congestive heart failure	□ hypertension	□ osteoporosis
□ anemia	□ chronic fatigue syndrome	□ hypogonadism male	□ pulmonary embolism
□ arthritis conditions	□ depression	□ hypothyroidism	□ blood clot in legs
□ asthma	□ diabetes	□ infection problems	□ seizure disorders
□ arterial fibrillation	□ drug/alcohol abuse	□ insomnia	□ shortness of breath
□ bleeding problems	□ erectile dysfunction	□ irritable bowel syndrome	□ sinus conditions
□ BPH	□ fibromyalgia	□ kidney problems	□ stroke
□ CAD coronary artery disease	□ GERD	□ menopause	□ syndrome X
□ cancer	□ heart disease	□ migraines/headaches	□ tremors
□ cardiac arrest	□ high cholesterol	□ neuropathy	□ wheat allergy
□ celiac disease	□ hyperinsulinemia	□ onychomycosis	

Medications-List any medications you are currently taking (please include over the counter medications). Please print legibly, no cursive.

Medication	Dosage	Prescribing Doctor

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date_____

I _____ give Kosse Community Health Clinic my permission to release any medical information (including diagnostic information, lab results and radiology reports) to the person/persons listed below.

I understand that if I do not list anyone below, no information will be given to anyone other than me.

Patient signature/Parent/Guardian signature if patient is a minor

_____

Patient signature/Parent/Guardian printed name

_____

Relationship to patient ☐ Self Other _____

Information can be released to:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Witness signature _____

Witness printed name _____

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Release of Information

I understand that:

Once this facility discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.

I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524)

My records are protected and cannot be disclosed without written permission.

This authorization will remain in effect for one year or until I provide a written notice of revocation to the Medical Record Department.

Signature of patient/parent or legal guardian_____ Date_____

Email_____

If signed by legal representative, relationship to patient_____

Signature of witness (optional)_____

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Kosse Community Health Clinic
206 N. Narcissus
Kosse, Texas 76653

Patient_____
(print patient name)

ACKNOWLEDGEMENT SIGNATURE SHEET

Patient Consent and Acknowledgement of Receipt of Privacy Notice:
I have been given a copy and read with total understanding all "Privacy Notice." I am signing this form, stating I consent to the use of disclosure of protected health information about me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

Patient/Guardian Signature_____ Date_____

Pain Medication Protocol:
I have been given a copy and read with total understanding of the "Physicians of Kosse Community Health Clinic Protocol" due to the regulations of the Texas Department of Public Safety, Regulatory Services Division. This is on all Scheduled 2, 3, 4 or 5 medications

Patient/Guardian Signature_____ Date_____

Prescription Medication Consent Form:
I have been given a copy and read with total understanding of the "Prescription Medication Form." I am agreeing that my provider at Kosse Community Health Clinic may request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing, but if you do it will not have an effect on any actions taken prior to receiving the revocation. Understanding the above, I hereby provide informed consent to Kosse Community Health Clinic to enroll me in the SureScripts® Program. I have had the chance to ask questions and ally my questions have been answered to my satisfaction.

Patient/Guardian Signature_____ Date_____

Financial Policy:

I have received a copy and read with total understanding the "Financial Policy." I understand that I am responsible for any and all outstanding balances.

Patient/Guardian Signature_____ Date_____

Scanned date_____
By_____

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PATIENT PORTAL FAQs

What is the LMC/KCHC patient portal?

The Limestone Medical Center/Kosse Community Health Clinic, patient portal is a convenient and secure health-management tool you can use anywhere you have access to the Internet. Through the portal, you can:

- View your clinical record summary for each visit
- In the future, be able to correspond with your health care team (coming soon!).

How old do I have to be to participate in the Limestone Medical Center/Kosse Community Health Clinic patient portal?

You must be at least 18 years old to participate in the LMC/KCHC portal.

How do I sign up for Limestone Medical Center/Kosse Community Health Clinic patient portal?

- When your registration has been completed, you will receive an email invitation to create your account
- Once you receive your email invitation, click the first link you see in the email and follow the directions

What is included in the Clinical Record Summary information?

The Limestone Medical Center/Kosse Community Health Clinic Patient Portal includes a view of clinical data from Limestone Medical Center/Kosse Community Health Clinic record. Your health record includes:

- Clinical Records Summary
  - Medications
  - Allergies
  - Immunizations
- Medications

Who can I contact if I have trouble logging in or accessing the LMC/KCHC portal?

Please contact the main number 254-729-3281 at Limestone Medical Center or 254-375-7001 at Kosse Community Health Clinic and speak to registration to have your password reset. If additional assistance is needed, you may speak with an IT Department staff member.

How can I obtain a copy of my entire medical record?

Please call our Hospital Medical Record Department at 254-729-3281 or our Kosse Community Health Clinic at 254-375-7001.

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PATIENT PORTAL AUTHORIZATION AND DISCLOSURE FORM

What is the Limestone Medical Center/ Kosse Community Health Clinic Patient Portal?

1. The Limestone Medical Center/ Kosse Community Health Clinic Patient Portal is a program that allows you online access to certain parts of your electronic medical record.

2. This service is entirely voluntary; if you wish to use this service, you must read this form and sign to authorize us to communicate with you via this mechanism.

Patient Portal Guidelines and Your Responsibilities:

1. Your login information and password protect the confidentiality of your health information. Please do not share your login or password with anyone.

2. Our patient portal is not for emergencies. In the event of an emergency, please call 911 or go to the nearest emergency department.

3. Limestone Medical Center/ Kosse Community Health Clinic Patient Portal is not responsible for any information that you share intentionally or unintentionally with others via email or through improper network security practices on your part. Please make every effort to safeguard your password.

4. Please note that our patient portal is not a substitute for timely contact and consultation with your doctor. You should never change or discontinue any course of treatment ordered by your doctor without first consulting with him or her.

5. You must be 18 years of age or older to use the patient portal.

Privacy: Limestone Medical Center/ Kosse Community Health Clinic Patient Portal has in place policies and procedures regarding access to medical records by our staff and employees.

1. Security: For your security, please do not transmit any requests over an unsecured web browser.

2. Please note that you can discontinue use of our patient portal at any time.

3. If for any reason we decide that you have violated the terms and/or abused the use of this service, or for any other reason, we can stop your use of this service at any time. You will be notified if we cancel your access to the Limestone Medical Center/ Kosse Community Health Clinic Patient Portal.

4. Any conflicts related to this agreement will be governed by and interpreted in accordance with the laws of the State of Texas.

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5. If you believe someone has learned your password, you should immediately go to the website and change it. You agree not to share your username and password with unauthorized persons and to maintain that username and password in a secure place at all times. Access to the Patient Portal is a free service but we reserve the right to change this policy if needed. We strive to keep all of your protected health care information completely confidential. If you cannot reset your password, please call and it can be reset for you.

Exclusion of warranty and limitation of liability:

Limestone Medical Center/ Kosse Community Health Clinic patient portal is provided as is and your use of it is exclusively at your own risk. We make not warranties, express or implied about the use of this portal or the materials in it, and disclaim any express or implied warranty of accuracy or quality and any implied warranty of merchantability, fitness for a particular purpose or non-infringement.

I understand that:

- I have the right to revoke this authorization, in writing, at any time by sending such written notification to the person authorized to make the disclosure, identified above.
- My revocation will not be effective to the extent that the authorized person has relied on the authorization before receiving the revocation, but will be effective from that date forward.
- Failure to furnish this authorization will not affect my medical treatment/eligibility or enrollment for health coverage or the payment of health benefits.
- Once disclosed, the protected health information may no longer be protected by federal or state law and could be disclosed again by the recipient.

_____ _____

Signature of Individual or Personal Representative Date

A fax or photocopy of this form shall be as effective as the original.

DOB_____

If a personal representative is signing this form on behalf of the individual whose medical information is to be disclosed, please print the personal representative's name and describe his or her authority to act on behalf of the individual.

Email address_____

A fax or photocopy of this form shall be as effective as the original

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