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____________________

Medical History Form

Name: ____ DOB: ____________
(Last) (First) (MI)
Address: ____
(Street) (City) (State) (Zip Code)
Telephone: ________________________ Marital Status: **S M W D**
Occupation: ________________________ Pharmacy: ________________________

Reason for today's visit: ____

PERSONAL MEDICAL HISTORY
Allergies (Medications/Food/etc.): ___________________________________
Bladder concerns: ____________________ Weight concerns: ____________________
Date of last Mammogram: _______________
Date of last colorectal screening: _______________
Date of last DEXA scan: __________________
Date of last PSA: __________________
Number of pregnancies/deliveries/Abortions: __________________
Number of Vaginal births/C-Sections: __________________
Any pregnancy/delivery complications? ____
Date of LMP: _______________ Date of last PAP: _______________
Any abnormal PAP? ________ Treatment for abnormal PAP?______________________
Are you sexually active? _______________ Current contraceptive: ________________
Do you smoke? _______________

- If yes, # per day: ______________ Stop date: ______________

Do you drink?

- If yes, # per day: ______________ Type of Alcohol: ______________

Drug use? __________________
Any Surgeries? ____
Current Medications: ____
____

Immunizations:
___ Flu – Date of last shot: ___________ ___ Pneumonia – Date of last shot: ___________
___ Tetanus – Date of last shot: ___________
___ COVID → Moderna/Pfizer/J&J Dose: 1st or 2nd Date of shot(s): ___________
___ COVID Booster – Date of shot: _________

FAMILY MEDICAL HISTORY
Mark if you or a family member has had any of the following:
___ Alcohol/Drug Use ___ Eating Disorders ___ Thyroid ___ Anemia
___ Bleeding Disorders ___ Heart Murmur ___ Heart Disease ___ Diabetes
___ High Blood Pressure ___ Kidney Disease ___ Stroke ___ Asthma
___ Anxiety ___ Depression
___ Cancer (type): ____
___ Other: ____

Other concerns: ____

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)____

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 _________________________

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.

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.

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

PATIENT CONSENT FORM

Authorization for Care: I grant permission to the employees of Kosse Community Health Clinic, a Limestone Medical Center clinic, to examine, treat and perform diagnostic tests and procedures that my provider deems necessary.

Authorization of Care by PA: I understand that my care may be provided by a Physician Assistant in consultation with a physician. There may or may not be a doctor of medicine or osteopathy present in the clinic 24 hours per day, seven days a week. My signature on this form constitutes my consent to treatment by this professional.

Assignment of Benefit-Insurance Assignment: In consideration of services rendered, I hereby assign and transfer to Kosse Community Health Clinic, a Limestone Medical Center clinic, my benefits payable for my benefit under hospitalization, sickness or accident insurance, and any other insurance coverage, to include major medical, for the payment of services rendered.

Financial Agreement and Responsibility: I understand that, regardless of my assigned benefits, I am responsible for all charges. I understand that Kosse Community Health Clinic, a Limestone Medical Center clinic, may file a claim for benefits on my behalf but, whatever my coverage, it is a personal contract between me and my insurance company. If benefits are not paid, I will be billed for the entire balance which I must pay in full upon receipt of the statement. I understand that I am responsible for charges not covered by this agreement and/or not paid by said companies and payers.

Medicare Lifetime Authorization: By signing below, I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration of the intermediaries or carrier any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and requested payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I further understand that I will assume full responsibility for any medical costs not covered by Medicare.

Non-Smoking Facility: I understand that this is a non-smoking facility and I will abide by this policy.

Valuables: I understand that Kosse Community Health Clinic, a Limestone Medical Center clinic, is not responsible for personal items (dental items, eye wear, jewelry, clothing, etc.) electively kept in my room or designated area while I am a patient. I further understand that patient care items left in the room following discharge will be disposed of an not replaced by Kosse Community Health Clinic, a Limestone Medical Center clinic.

HIV, HBV and HCV Testing After an Accidental Exposure: Texas law authorizes a hospital or physician to require that a patient be tested for possible exposure to the Human Immunodeficiency Virus, Hepatitis B virus and Hepatitis C virus in the following situations: (1) if donation of blood, blood products, organs or tissues is contaminated; (2) if a healthcare worker is accidentally exposed to a patient's blood or bodily fluids; or (3) if a medical surgical procedure is to be performed which could expose health care workers to the patient's blood or bodily fluids. This disclosure informs that you may be tested if any of these situations occur during your hospitalization. I consent to HIV, HBV and HCV testing under any of the above situations.

Privacy Practices: Kosse Community Health Clinic, a Limestone Medical Center clinic, is required by law to maintain the privacy of a patient's protected health information (PHI). In addition, we are required by law to provide individuals with a notice of our legal duties and privacy practices, if requested, with respect to PHI.

Patients' Rights and Responsibilities: I have been given the opportunity to review my rights and responsibilities as a patient. I understand my rights because they have been explained to me and my questions have been answered.

Authorization to Release Information: By signing below, I authorize Kosse Community Health Clinic, a Limestone Medical Center clinic, to release information requested by insurance companies, review agencies or other third-party payers for payment of claims arising out of this visit. I give permission, without limitation or exclusion, for Kosse Community Health Clinic, a Limestone Medical enter clinic, and its providers to view my external prescription history for purposes of my care and treatment. I understand that my medication history from multiple other medical providers, insurance companies and pharmacy health benefit managers may be viewable and that granting this permission will allow my providers to better coordinate my care and to maximize the effectiveness and safety of my treatment plan.

______________________________ Signature of Patient or Patient's Representative

______________________________ Date and Time

______________________________ Witness Signature

______________________________ Date and Time

206 N. Narcissus
Kosse, Texas 76653

Phone: 254-375-7001 Fax: 254-375-2233

MEDICAL RECORDS RELEASE CONSENT

Patient Name: ______________________________ DOB: ______________

Patient Address: ______________________________

City, State, Zip: ______________________________

This authorizes to release or disclose information from the records of the above-named patient to/from:

To: Heather Flippin	From: ______________
Address: 206 N. Narcissus	Address: ______________
City, State, Zip: Kosse, TX 76653	City, State, Zip: ______________
Phone: 254-375-7001	Phone: ______________
Fax: 254-375-2233	Fax: ______________

The purpose of this disclosure is: ______________________________

The information to be disclosed is limited to: (circle item(s) to be disclosed)

Discharge Summary	Physician Orders	Progress Notes	Birth Records	Treatment Plan
Consultation	Entire Record	Last 2 Years	X-Ray	Labs

The consent of disclosure is subject to revocation at any time except to the extent that action has been taken in reliance thereon (i.e. information already disclosed). My signature means that I have read this form and/or have had it read to me and explained in language that I can understand. I hereby release the above from any legal liability resulting from the release of this information. The consent of disclosure will expire ninety (90) days after the termination of therapy, or as otherwise specified by date, even or condition as follows, unless revoked by me.

Signature of Patient: ______________________________ Date: ______________

Signature of Parent or Guardian: ______________________________ Date: ______________

Signature of Staff Member: ______________________________ Date: ______________

To the receiving party of this information: this information has been disclosed to you from the records protected by Federal Confidentiality rules (42 CRF Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.