CENTERSTONE
HEALTH SERVICES

Patient Registration

Legal Name: _____ **Preferred Name**: _____
Last, First First Only

Sex: ☐ Male ☐ Female Date of Birth: ___/____/_____ Social Security Number: _____-_____-_____

Address: _____ City: _____State: _____ Zip Code: _____
Homeless: ☐ Yes ☐ No
Mobile Telephone: _____-_____-_____ Home/Other Telephone: _____-_____-_____
Email Address: _____ ☐ No Email

How many people live in your household? 1 2 3 4 5 6+ Estimated Household Annual Income: $_____

Guarantor/ Responsible Party Information ☐ Same as Patient
Relationship to Patient: _____
Name: _____ Date of Birth: __/____/____ Telephone: _____-_____-_____
Address: _____ City: _____State: _____ Zip Code: _____

Emergency Contact Information ☐ Same as Responsible Party
Name: _____ Telephone: _____ Relationship: _____
May we discuss appointment and billing information? ☐ Yes ☐ No

Preferred Language: ☐ English ☐ Spanish Other: _____

Race: ☐ White ☐ Black ☐ Asian Other: _____ ☐ Decline to disclose

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Decline to disclose

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

Sexual Orientation: ☐ Straight/Heterosexual ☐ Lesbian, Gay/Homosexual ☐ Bisexual ☐ Decline to disclose

Gender Identity: ☐ Male ☐ Female ☐ Transgender (MTF or FTM) ☐ Binary ☐ Other ☐ Decline to disclose

Pronouns: ☐ He/him ☐ She/her ☐ They/them **Assigned Sex at Birth:** ☐ Male ☐ Female

Veteran: ☐ Yes ☐ No **Agricultural Worker:** ☐ Yes ☐ No

Insurance Information

Primary Insurance Company Name: _____ Policy ID#: _____
Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other
Name of Policy Owner/Subscriber: _____
Policy Holder Address: _____ City: _____ Zip Code: _____
Policy Holder Date of Birth: ____/_____/____ Policy Holder Phone Number: ____-_____-_____
Policy Holder Employer: _____ Group ID#: _____

Preferred Pharmacy: _____ Telephone Number: _____-_____-_____
Address: _____ City: _____ State: _____

Do you have a Centerstone Health Primary Care Provider? Y or N
Do you have a Centerstone Health Behavioral Health Care Provider? Y or N

How did you hear about Centerstone Health Services?_____

CENTERSTONE
HEALTH SERVICES

History and Review of Systems

Patient Name: _____ DOB: _____

Health History **Check all that apply**	Alive (Y/N)	Age	Cause of Death	**Alcoholism**	**Anxiety Disorder**	**Arthritis**	**Asthma/COPD**	**Bleeding Disorder**	**Cancer**	**Depression**	**Diabetes**	**Heart Disease**	**Hepatitis C**	**High Blood Pressure**	**High Cholesterol**	**HIV or AIDS**	**Kidney Disease**	**Liver Disease**	**Mental Illness**	**Migraines**	**Stomach Issues/ Reflux**	**Stroke**	**Thyroid Disease**
Self																							
Father																							
Mother																							
Sibling(s)																							
Grandmother																							
Grandfather																							

Medications and Allergies

Medication Allergies: _____

Drug Name	**Strength**	**Frequency Taken**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you have more medications than can be listed, please bring ALL medications/list with you to your visit.

Surgical History

Surgery	**Year/ Age**	**Surgery**	**Year/ Age**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Social History

Education ☐ Less than 8th Grade
☐High School ☐2 year College
☐4 year college ☐ Post Graduate

Caffeine ☐ None ☐Occasional
☐Moderate ☐Heavy
# of cups/cans per day? _____

Tobacco Do you use tobacco? ☐Yes ☐No
☐Cigarettes - ____packs/day
☐Chew- _____/day
☐Cigars- _____/day
# of Years or Year Quit: _____

Marital Status ☐ Married ☐Single ☐Divorced ☐Separated
☐Widowed ☐Domestic Partner

Alcohol Do you drink alcohol? ☐Yes ☐No
If yes, how often? ☐Occasionally ☐<3 times per week
☐>3 times per week # of drinks per week? _____

Drugs Do you currently use recreational or street drugs?
☐Yes ☐No
If yes, list: _____

Exercise Level ☐None ☐Occasional ☐Moderate ☐High

CENTERSTONE
HEALTH SERVICES

History and Review of Systems

Patient Name: _____ DOB: _____

Review of Systems

Please check all that apply:

Allergic/Immunologic

☐Frequent Sneezing
☐Hives
☐Itching
☐Runny Nose
☐Sinus Pressure

Cardiovascular:

☐Arm Pain on Exertion
☐Chest Pain on Exertion
☐Chest heaviness/pressure on exertion
☐Irregular Heart Beats
☐Known Heart Murmur
☐Light-Headed on standing
☐Shortness of Breath when Lying
☐Shortness of Breath when Walking
☐Swelling (edema)

Constitutional

☐Exercise Intolerance
☐Fatigue
☐Fever
☐Weight Change (Loss/Gain)

Eyes

☐Dry Eyes
☐Irritation
☐Vision Change
Date of Last Eye Exam:
_____

Ears/Nose/Mouth/Throat

☐Bleeding Gums
☐Difficulty Hearing
☐Dizziness
☐Dry Mouth
☐Ear Pain
☐Frequent Infections
☐Frequent Nosebleeds
☐Hoarseness
☐Mouth Breathing
☐Mouth Ulcers
☐Nose/Sinus Problems
☐Ringing in Ears
Date of last Dental Exam:
_____

Endocrine

☐Fatigue
☐Increased Thirst/ Hunger/ Urination

Gastrointestinal:

☐Abdominal Pain
☐Black or Tarry Stool
☐Blood in Stool
☐Change in Appetite
☐Frequent Indigestion
☐Hemorrhoids
☐Trouble Swallowing
☐Vomiting
☐Vomiting Blood
Date of last colonoscopy:
_____

Genitourinary

☐Blood in Urine
☐Difficulty Urinating
☐Incomplete Emptying
☐Increased Urinary Frequency
☐Urinary Loss of Control

Hematologic/Lymphatic:

☐Easy Bruising/Bleeding
☐Swollen Glands

Integumentary (Skin)

☐Changes in Moles
☐Dry Skin
☐Eczema
☐Growth/Lesions
☐Itching
☐Jaundice (Yellow skin/eyes)
☐Rash

Musculoskeletal

☐Back pain
☐Joint pain
☐Muscle Aches
☐Muscle Weakness

Neurological

☐Dizziness
☐Fainting
☐Headaches
☐Memory Loss
☐Migraines
☐Numbness
☐Restless Legs
☐Seizures
☐Weakness

Psychiatric

☐Alcohol Overuse
☐Anxiety/Stress
☐Depression
☐Do Not Feel Safe
☐Mania
☐Sleep Problems

Respiratory

☐Cough
☐Coughs up Blood
☐Shortness of Breath
☐Sleep Apnea
☐Snoring
☐Wheezing

CENTERSTONE
HEALTH SERVICES

Conditions of Service/ Consent to Treat/ NPP

1. I consent to exam and treatment as necessary, including acquisition of medical, behavioral health and pharmaceutical history. I hereby authorize Centerstone Health Services (CHS) to release any information regarding services rendered by Centerstone Health Services to my insurance company and in the case of Medicare and the Health Care Financing and its agents; and allow a photocopy of my signature to be used to file insurance, including Medicare, when applicable. I request that payment, including Medicare- authorized benefits be made either to me or on my behalf to Centerstone Health Services. I authorize and direct my insurer to issue payment for authorized benefits due me for services rendered by Centerstone Health Services to be made directly to Centerstone Health Services. Regardless of my health insurance benefits, if any, I understand that I am financially responsible for the fees for services and any cost incurred.
2. My participation in telehealth services is voluntary. I verify that telehealth services have been explained to me and I voluntarily agree to participate. I understand that all information about me will remain confidential and will be used only for treatment purposes.
3. With my consent, Centerstone Health Services (CHS) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). The CHS Notice of Privacy Practices (NPP) lists a complete description of such uses and disclosures and I have the right to review and receive if requested the NPP prior to signing this consent. CHS reserves the right to revise its Notice of Privacy Practices at any time.
4. With my consent, CHS may call my home, cell or designated location and leave a message on voicemail or in person about any items that assists CHS in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including lab results among all others. With my consent, CHS may mail to my home or other designated location any items that assists CHS in carrying out TPO, such as appointments, reminder cards and statements. With my consent, CHS may send SMS and email messages to my mobile telephone or email address that I provide about any items that assists CHS in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including lab results among all others.
5. Authorization is hereby granted to receive and to release all medical record information of treatment for physical and/or emotional illness, including pharmacy, treatment of drug and alcohol abuse to another health care provider, including faxing this information upon my transfer for further care.
6. With my consent, CHS may receive and release all information regarding my immunization information with the Children and Hoosiers Immunization Registry Program (CHIRP). This information may be faxed, emailed, mailed or electronically transmitted via secure CHIRP website or CHS electronic medical record.
7. I have the right to request that CHS restrict how it uses or discloses my PHI to carry out TPO. However, CHS is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I, THE UNDERSIGNED, CERTIFY THAT I HAVE READ THE FOREGOING, AND AM THE PATIENT, OR AM DULY AUTHORIZED AS PATIENT'S AGENT TO EXECUTE THE ABOVE AND I ACCEPT ITS TERMS.

_____ _____

Patient's Name Date of Birth

_____ _____

Signature of Patient or Legal Guardian Date

_____

Printed Name of Patient or Legal Guardian

CENTERSTONE
Health Services

Patient Name: _____ Date of Birth: ____/____/_____

Sliding Fee Discount Program (2023)

- Centerstone Health Services offers a discount on all onsite services for patients whose household income listed below. To participate in this program you must submit proof of income and a completed application.

To see if you qualify, please CIRCLE your family size and income category below:

	Fee Category				
	A	**B**	**C**	**D**	**N/A**
Fee per family member, per visit:	**Patient Pays $10**	**Patient Pays $25**	**Patient Pays $40**	**Patient Pays $55**	**100% of Charges**
Family Size	**Annual income less than or equal to**	**Annual income less than or equal to**	**Annual income less than or equal to**	**Annual income less than or equal to**	**Annual Income more than**
1	**$14,580.00**	**$21,870.00**	**$25,515.00**	**$29,160.00**	**$29,160.00**
2	**$19,720.00**	**$29,580.00**	**$34,510.00**	**$39,440.00**	**$39,440.00**
3	**$24,860.00**	**$37,290.00**	**$43,505.00**	**$49,720.00**	**$49,720.00**
4	**$30,000.00**	**$45,000.00**	**$52,500.00**	**$60,000.00**	**$60,000.00**
5	**$35,140.00**	**$52,710.00**	**$61,495.00**	**$70,280.00**	**$70,280.00**
6	**$40,280.00**	**$60,420.00**	**$70,490.00**	**$80,560.00**	**$80,560.00**
7	**$45,420.00**	**$68,130.00**	**$79,485.00**	**$90,840.00**	**$90,840.00**
8	**$50,560.00**	**$75,840.00**	**$88,480.00**	**$101,120.00**	**$101,120.00**
Each Add'l Person:	**$5,140.00**	**$7,710.00**	**$8,995.00**	**$10,280.00**	**$10,280.00**

Patient Signature: _____ Date: ____/____/_____

☐ **At this time, I decline the Discounted Fee Schedule.**

Revised 1/23/23 DM/kp

CENTERSTONE
HEALTH SERVICES

Authorization to Release Records to Family Members

Under the requirements of HIPAA, we are not allowed to give medical or billing information to anyone without patient consent. However, many patients allow family members such as spouses, parents or others to call and request this information. If you wish to have your medical or billing information released to family members, you must sign this form.

This will ONLY give information to family members indicated below.

I, _____, born on _____, hereby authorize Centerstone Health Services to release my
Patient's Name Date of Birth
medical and/or billing information to the following individuals:

Name of Relative	Relationship to Patient	Telephone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

I understand that I have the right to revoke this content in writing.

_____ _____
Patient Signature Date

_____
Patient Name Printed

CENTERSTONE
Health Services

645 S Rogers Street
Bloomington, IN 47403
812-269-5092
Fax: 812-269-5095

390 East Erie Street Suite A
Connersville, IN 47331
765-377-1205
Fax: 765-377-1209

831 Dillon Dr
Richmond, IN 47374
765-200-7900
Fax: 765-200-7901

720 N Marr Road
Columbus, IN 47201
812-669-3061
Fax: 812-669-3070

Authorization to Release/Obtain Confidential Information

Patient's Name (Printed): _____ **DOB:** _____ **Chart ID:** _____ **Last 4 SSN:** _____

Address: _____

Phone Number: _____

I hereby authorize Centerstone Health Services to ☐ obtain information from: ☐ release information to: ☒ release and obtain information from:

CENTERSTONE OF INDIANA

The above information is released for the following purpose:

☒ Continuation of Care ☐ Legal Purposes ☐ Insurance Purposes ☐ Employer Requirement ☐ At Patient's Request ☐ Other: _____

Information to be released:

- ☐ Discharge Summary
- ☐ Consultation
- ☐ ER Report
- ☐ Last Three Pap Results
- ☐ Cologuard Results
- ☐ Sleep Studies
- ☐ Release ***entire*** record
- ☒ Labs for Last 12 Months
- ☐ Operative Report
- ☐ EKG / Cardiology Report Current
- ☐ Current Mammogram
- ☐ Diagnostics
- ☐ Immunization Record
- ☒ Physician's Orders/Progress Notes for Last 3 visits
- ☐ Pathology Report(s)
- ☐ Radiology Report
- ☐ Previous Medicare Wellness Visit & Associated Labs Results
- ☐ Current Dexascan
- ☐ Current Pulmonary Function Test Results
- ☐ Eye Exams

Dates to be released: ☐ All treatment dates ☐ Date from: _____ Date to: _____

Indicate specific information to be *EXCLUDED* from this authorization, if any: (Check all that apply)

☐ Mental Health ☐ Genetic Information ☐ Drug & Alcohol ☐ HIV/AIDS ☐ Infectious Disease

I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies/electronic media of my health information.
I understand that the person(s) and /or organizations(s) listed above whom I am authorizing to use and /or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. Revocation Process: I understand that I may by placing my request in writing to the Centerstone Health Services revoke this authorization at any time except to the extent that action has been taken in reliance on it and that in any event this authorization will expire one year from the date of my signature or as otherwise specified by date, event or condition as follows. Photocopy: I further authorized that a photocopy of this authorization form will be fully acceptable as an original and that Centerstone Health, may deny the release of protected health information, if it has reason to believe this authorization has been altered or is not a true and accurate authorization initiated by the patient. Fees for copies: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to prepay for the copies; if not, then your copies will be mailed along with an invoice.
I voluntarily authorize the use or disclosure of my protected health information to Requestor, either verbally, in writing, and/or facsimile, as described above.

Signature: _____ Printed Name: _____

Date: _____ Description of Representative's Authority to Act (if applicable): _____

Relationship to Individual: ☐ Self ☐ Parent ☐ Guardian (Proof Required) ☐ Authorized Representative (Proof Required)

Prohibition of re disclosure except as provider under Federal Law 45 CFR 164.524. This information has been disclosed from records whose confidentiality is protected by Federal Law 42 CFR Part 2. This recipient of this information is prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical information is not sufficient for this purpose.