2025 Patient Registration

Patient Information and Demographics

Patient Full Name: _____

Physical Address: _____

City: _____ **State:** _____ **Zip:** _____

Mailing Address (If different from physical address):

_____

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Date of Birth: _____ **Social Security Number:** _____

Birth Gender: ☐ Male ☐ Female

Race:

☐ Asian (Please circle): Asian Indian Chinese Filipino Japanese Korean Vietnamese Other

☐ Native Hawaiian/Other Pacific Islander (Please Circle): Native Hawaiian Other Pacific Islander Guamanian/Chamorro Samoan

☐ Black/ African American ☐ American Indian/Alaska Native ☐ White ☐ More than one race

☐ Unreported/Chose not to disclose race

Ethnicity:

☐ Non Hispanic or Latino ☐ Andalusian ☐ Argentinean ☐ Asturian ☐ Belearic Islander
☐ Bolivian ☐ Canal Zone ☐ Canarian ☐ Castillian ☐ Catalonian ☐ Central American
☐ Central American Indian ☐ Chicano ☐ Chilean ☐ Columbian ☐ Costa Rican
☐ Criollo ☐ Dominican ☐ Ecuadorian ☐ Gallego ☐ Guatemalan ☐ Hispanic/Latino
☐ Honduran ☐ La Raza ☐ Latin American ☐ Mexican ☐ Mexican American
☐ Mexican American Indian ☐ Mexicano ☐ Nicaraguan ☐ Non Hispanic or Latino ☐ Panamanian
☐ Paraguayan ☐ Peruvian ☐ Puerto Rican ☐ Salvadoran ☐ South American
☐ South American Indian ☐ Spaniard ☐ Spanish Basque ☐ Uruguayan
☐ Valencian ☐ Venezuelan ☐ Declined to Answer ☐ Refused to Report

Marital Status:
☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Life Partner ☐ Widowed

Education Level: ☐ Grade School ☐ High School ☐ College ☐ Post-Grad ☐ Other

Household Size (Number of people living in your house): _____

Income Level (Total Household Income): _____

Housing Status: ☐ Rent ☐ Own ☐ Public Housing ☐ Homeless (Living in a Vehicle, Couch Surfing)

☐ Living with A Family Member (Not Paying Rent)

Are you a Veteran? ☐ Yes ☐ No

If over the age of 18, do you have a living will? ☐ Yes ☐ No
If yes, please provide a copy.

If over the age of 18, do you have a Do Not Resuscitate form? ☐Yes ☐No
If yes, please provide a copy.

How did you hear about us? _____ (family, friend, google, billboard, referral, signs)

COMMUNICATION PREFERENCES

One Cross Community will call or text you 48 hours in advance of your scheduled appointment(s). We will also call you if there are any changes to your appointment time. Messages will only be sent out between 8:30 am and 5:00 pm. Please indicate your communication preferences.

Appointment Reminders:

Text Message Reminder: ☐Yes ☐No Preferred Time of Reminders:
☐ Morning ☐ Afternoon ☐ Evening

Voice Call Reminder: ☐ Yes ☐ No

☐Home ☐ Cell Preferred Contact Number: ☐ Home ☐ Cell

Type of Reminders You Want to Receive

☐ Appointments ☐ Prescription Confirmation ☐ Labs ☐ General Notifications ☐ Health Maintenance

Do we have permission to leave a message on your answering machine? ☐ Yes ☐ No

Do we have permission to contact you through email? ☐ Yes ☐ No

☐ By checking this box you agree to receive recurring messages from One Cross Community, Reply STOP to Opt out; Reply HELP for help; Message frequency varies; Message and data rates may apply; Carriers are not liable for delayed or undelivered messages.

Your Preferred Pharmacy: _____

Phone: _____

Updated 11/25

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COMMUNITY HEALTH & WELLNESS

PAST MEDICAL HISTORY

Patient Full Name: _____ Date of Birth: _____

Are you currently taking any medications or drugs including natural supplements, herbs, OTC medications or vitamins? ☐ Yes ☐ No *If yes, please list*: _____

_____

Do you have any drug or other allergies (ex. food, seasonal)? ☐ Yes ☐ No

If yes, please list: _____

Have you ever had a major operation or been hospitalized? ☐ Yes ☐ No

If yes, please describe: _____

Have you had or do you currently have any of the following:

☐ ADHD	☐ Bruise Easily	☐ Fainting/Dizzy	☐ Hypoglycemia	☐ Recent Weight Loss
☐ AIDS/HIV Positive	☐ Cancer	☐ Frequent Cough	☐ Irregular Heartbeat	☐ Rheumatic Fever
☐ Alzheimer's Disease	☐ Chemotherapy	☐ Frequent Headache	☐ Kidney Dialysis	☐ Scarlet Fever
☐ Anaphylaxis	☐ Chest Pains	☐ Glaucoma	☐ Leukemia	☐ Shingles
☐ Anemia	☐ Cold Sores/Fever Blisters	☐ Heart Attack/Failure	☐ Liver Disease	☐ Sickle Cell Disease
☐ Angina	☐ Congenital Heart Disorder	☐ Heart Murmur	☐ Low Blood Pressure	☐ Sinus Trouble
☐ Arthritis/Gout	☐ COPD	☐ Heart Pacemaker	☐ Lung Disease	☐ Spina Bifida
☐ Artificial Heart Valve	☐ Cortisone Medicine	☐ Heart Trouble/ Disease	☐ Mitral Valve Prolapse	☐ Stomach/Intestinal Disease
☐ Artificial Joint	☐ Diabetes	☐ Hemophilia	☐ Multiple Sclerosis	☐ Stroke
☐ Asperger's Syndrome	☐ Drug Addiction	☐ Hepatitis A	☐ Muscular Dystrophy	☐ Swelling of Limbs
☐ Asthma	☐ Easily Winded	☐ Hepatitis B or C	☐ Osteoporosis	☐ Thyroid Disease
☐ Autism	☐ Emphysema	☐ Herpes	☐ Pain in Jaw Joints	☐ Tonsillitis
☐ Blood Disease	☐ Epilepsy/Seizure	☐ High Blood Pressure	☐ Parathyroid Disease	☐ Tuberculosis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ High Cholesterol	☐ Psychiatric Care	☐ Tumors or Growths
☐ Breathing Problems	☐ Excessive Thirst	☐ Hives or Rash	☐ Radiation Treatments	☐ Ulcers
				☐ Yellow Jaundice

Have you had another illness/condition not listed? ☐ Yes ☐ No *If yes,what?*_____

Do you use tobacco products? ☐ Yes ☐ No *If yes, what?*_____

Do you use alcohol? ☐ Yes ☐ No *If yes, what?*_____

Do you use controlled substances? ☐ Yes ☐ No *If yes, what?*_____

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Women, please let us know if you are: ☐Pregnant ☐Trying to get pregnant ☐Nursing ☐Taking oral contraceptives

Have you received or do you plan to receive: ☐This year's flu shot ☐Pneumonia vaccine ☐Covid Vaccine

*If yes to any, when and where?*_____

Are you currently under another physician's care? ☐ Yes ☐ No *If yes, who?*_____

INSURANCE INFORMATION

Primary Insurance: _____

Secondary Insurance: _____

GUARANTOR INFORMATION

Guarantor Full Name: _____

Relationship to Patient: _____

Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Date of Birth: _____ Social Security Number: _____

Employer: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____

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EMERGENCY CONTACT

Emergency Contact: _____

Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

If we are allowed to release patient information to someone other than the patient, list them below:

	Name	Relationship to Patient	Phone Number
1.			
2.			

OR

DO NOT release information to anyone other than the patient. _____ *(initial)*

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Full Name: _____

Patient Date of Birth: _____

1. I authorize _____ to release my information from my medical record to One Cross Community. This authorization included release of radiology, film, digital media, photographs, and/or videotapes if required.
2. This authorization includes release of information concerning treatment of psychiatric/psychological conditions, drug and/or alcohol-related conditions, and HIV or AIDS-related conditions.
3. The type and amount of information to be used or disclosed are as follows (including dates when possible)

   Entire record from: _____

   Dates Requested

   ___ Discharge Summary (most recent)
   ___ H&P (most recent)
   ___ Lab Results (most recent/last 6 mths)
   ___ Path Result (most recent/last 6 mths)
   ___ ER Record (most recent)
   ___ OP Note (most recent)
   ___ Consult Report (most recent)
   ___ X Ray Report (most recent/last 6 mths)
   ___ Other (please specify) _____

4. The information above is being released to One Cross Community.
5. I understand that I have the right to revoke this authorization at any time, but any revocation must be presented to One Cross Community. I understand that treatment, payment, enrollment to any health plan or eligibility for health benefits are NOT affected by signing this authorization.
6. Once these records are released, the information is not protected by One Cross Community and may be re-disclosed by the party who received these records.
7. I understand that I may inspect the information that will be disclosed, but this inspection must be arranged by One Cross Community at the time.
8. This authorization will expire 12 months, or until consent is withdrawn, after it is signed and I will have to sign a new release form. The undersigned acknowledges that the provision of free medical records by any person who receives this release shall fulfill the obligation to provide one (1) free copy of the medical records and that any future requests for my medical records from One Cross Community may result in a copying fee of up to one dollar ($1.00) per page.

_____ _____
Patient Signature *Date*

_____ _____
Parent, Guardian, or Authorized Representative *Witness*

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow up among the multiple Healthcare providers who may be involved in that treatment indirectly
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have had the opportunity to receive, read and understand your *Notice of Privacy Practices,* containing a complete description of the uses and disclosures of my health information. I understand that this office has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at 106 Winston Way, Campbellsville, KY to obtain a current copy of the *Notice of Privacy Practice.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

_____ _____

Patient Signature *Date*

_____ _____

Parent, Guardian, or Authorized Representative *Date*

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CONSENT TO TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may decide whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. No specific treatment plan has been recommended at this point in your care. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions. I voluntarily request a physician and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms before the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient Signature *Date*

_____ _____

Parent, Guardian, or Authorized Representative *Relationship to patient*

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CONTROLLED SUBSTANCE AGREEMENT

Controlled substances have potential to be addictive and must be taken exactly as described. I,_____, understand that if I am prescribed a controlled substance I must adhere to the following restrictions. **Failure to conform to any of the below listed restrictions may result in being dismissed as a patient of One Cross Community and being reported to the police.**

PLEASE INITIAL EACH STATEMENT

1. ____ I will not use alcohol/illegal drugs while being prescribed medication(s).
2. ____ I will not take any other prescribed medications without first notifying my provider.
3. ____ I will notify the office immediately of any other physician(s) currently prescribing me a controlled substance(s) or that have been prescribed to me in the last thirty days (including Emergency Rooms and Immediate Care Centers). **Failure to do so is a crime (Obtaining or Attempting to Obtain Drugs by Fraud and/or Deceit) and will be reported to the police.**
4. ____ I will submit to random urine and/or serum drug screens as ordered.
5. ____ I will purchase all of the medications at _____ pharmacy and authorize the providers of One Cross Community to communicate with my pharmacist.
6. ____ I authorize the providers of One Cross Community to communicate with my primary care physician.
7. ____ I understand that it is illegal to share this medication.
8. ____ I agree to keep my medication locked in order to prevent loss or theft.
9. ____ I understand that I will be taken off this medication if there is evidence of addiction and/or abuse.
10. ____ I understand that this medication may cause drowsiness and slower reflexes, interfering with my ability to drive and operate machinery, and short-term memory impairment.
11. ____ I agree to keep all scheduled appointments with my provider/therapist. My medication may be weaned and/or discontinued if I fail to attend my scheduled appointments.
12. ____ I also understand that part of my treatment may include reduction and discontinuation of any addictive medications.
13. ____ I authorize this office to release a copy (or original) of this controlled substance agreement to the police if I violate any of the listed terms at their request.
14. ____ (Y/N) Have you received **ANY** prescription medications from **ANY** other provider in the last thirty days? If yes, please list the provider and medication on the back.
15. ____ I understand that I may be called at any time to the office for a count of all remaining medications. I agree to arrive on the day notified and will be responsible for any costs this may incur.
16. ____ I waive my right of privacy and authorize One Cross Community to contact any health care provider, legal authority, friend and/or relative in order to obtain or provide information about my care (including abuse of controlled substances).

No refills will be authorized on weekends, holidays, after hours, or by producing a police report.
Lost/stolen medications will not be replaced.

_____ _____

Patient Signature *Date*

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FINANCIAL POLICY & PATIENT AGREEMENT

One Cross Community appreciates your business and values the opportunity to provide holistic care for you and your family. In order to be able to keep providing excellent care in our community. We must request your cooperation with our financial policy. Patient financial expectations will be as follows.

- Applicable copays, deductibles, and coinsurance will be due at the time of your visit. We will calculate this amount to the best of our ability; however, we cannot anticipate all processing possibilities.
- Any unanticipated remaining balance from your visit will be due within 30 days after the claim is processed by your insurance company. You will receive an Explanation of Benefits in the mail from your insurance company to alert you of any patient responsibility that may be due.
- Self-pay patients will be expected to pay in full upon check-in.
- Previous balances will be required to be paid before being seen unless a formal payment arrangement is made with the office.
- All payment agreements must be honored in good faith. If payments are missed another appointment cannot be made until the scheduled payment is made, unless approved by management.
- A credit/debit card on file will be required for all patients who have entered a payment arrangement and will be voluntary for the convenience of all other patients. This card information will be safely stored in an encrypted system.
- If a patient with a past due balance does not make a payment for 3 consecutive months. The balance will be subject to:
    - Possible collection services
    - The loss of patient privileges outside of emergency care.

I understand and agree to these guidelines.

_____ _____

Patient Signature *Date*

_____

Parent, Guardian, or Authorized Representative

PATIENT VIDEO/AUDIO MONITORING CONSENT

I understand that One Cross Community strives to provide high-quality healthcare services to our patients, their families, and caregivers, as well as to work with other healthcare facilities, insurance companies, and other community agencies professionally in person, telephone, and other electronic means of communication. To ensure that our standards of care are followed all telephone calls are recorded and may be reviewed for quality purposes at any time. In addition, video camera footage may be reviewed at any time to ensure One Cross Community's principles and standards are always upheld.

Taped recordings may also be used on social media platforms, advertising, educational platforms, or reviewed by management at any given time without prior notice given,

This consent form shall remain valid throughout my time as a patient at One Cross. My signature on this form acknowledges consent and agreement to the above-stated information.

Printed Name: _____

Signature: _____ Date: _____