102 Winston Way #5
Campbellsville, KY 42718
P: (270) 789-0034
F: (270) 789-0097
info@onecrosshealth.com

NEW PATIENT REGISTRATION
www.onecrosshealth.com

PERSONAL INFORMATION & DEMOGRAPHICS

Patient Full Name: ____

Address: ____

City: ____________________________ State: ______________________ Zip: ____________

Physical Address (If Mailing Address is a P.O. Box):

____

Home Phone: _________________________ Cell Phone:_____________________________

Email address: ____

Date of Birth: _________________________ Social Security Number: ___________________

Sex: M:__ F:__ Race:__________ Ethnicity:__________ Language: __________

Single:__ Married:__ Legally Separated:__ Divorced:__ Life Partner:__ Widowed:__

Education Level: Grade School:__ High School:__ College:__ Post-Grad:__ Other:______

If over the age of 18, do you have a Living Will or a Do Not Resuscitate form? Yes:__ No:__
If yes, please provide a copy.

Who can we thank for referring you to us? ____

COMMUNICATION PREFERENCES

One Cross Medical Clinic 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 8:30am and 5:00pm. Please indicate your communication preferences.

Appointment Reminders:

Text Message Reminder: Yes:__ No:__
Voice Call Reminder Yes:__ No:__
Home:__ Cell:__

Preferred Time of Reminders:
Morning:__ Afternoon:__ Evening:__

Type of Reminders You'd Like 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:__

Your Preferred Pharmacy: ____

INSURANCE INFORMATION

Primary Insurance: ____

Secondary Insurance: ____

GUARANTOR INFORMATION

Relationship to Patient: ____

Address (*if different than patient*): ______________________________________

City: ______________________ State: ____________________ Zip: __________

Home Phone: ____________________ Cell Phone:______________________

Email address: ____

Date of Birth: ____________________

Employer: ____

Work Address: ____

City: ______________________ State: ____________________ Zip: __________

Work Phone: ____________________

EMERGENCY CONTACT

Emergency Contact: ____

Relationship to Patient: ____

Home Phone: ____________________ Cell Phone:______________________

DISCLOSURE OF HEALTH INFORMATION TO OTHER INDIVIDUALS

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 patient: _____ *(initial)*

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Full Name: ____

Patient Date of Birth: ____

1. I authorize ___________________________ to release information from my medical record to One Cross Medical Clinic. This authorization includes 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 as follows (includes dates when possible)

   Entire record from: ____

   Dates Requested

   ____ Discharge Summary (most recent)
   ____ H&P (most recent)
   ____ Lab Results (most recent/last 6 mths)
   ____ Path Report (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 Medical Clinic.
5. I understand that I have the right to revoke this authorization at any time, but any revocation must be presented to One Cross Medical Clinic. 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 Medical Clinic and may potentially 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 at a time arranged by One Cross medical Clinic.
8. This authorization will expire 6 months 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 Medical Clinic may result in a copying fee of up to one dollar ($1.00) per page.

____
Patient Signature

____
Date

____
Parent, Guardian, or Authorized Representative

____
Witness

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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 more 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 the address of 102 Winston Way, Campbellsville KY to obtain a current copy of the *Notice of Privacy Practices*.

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 operation. 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.

____
Name (print)

____
Relationship to Patient

____
Signature

____
Date

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CONTROLLED SUBSTANCE AGREEMENT

Controlled substances have the 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 Medical Clinic 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 past thirty days (including Emergency Rooms and Immedicate 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 my medications at __________________ pharmacy and authorize the providers of One Cross Medical Clinic to communicate with my pharmacist.
6. ____ I authorize the providers of One Cross Medical Clinic 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 discontinued if I fail to attend my scheduled appointments.
12. ____ I also understand that part of my treatment may involve 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 Medical Clinic 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 office hours, or by producing a police report.
Lost/stolen medications will not be replaced.

_______________________________________ _____________________________
Patient Signature *Date*

_______________________________________ _____________________________
Provider Signature *Date*

FINANCIAL POLICY & PATIENT AGREEMENT

One Cross Medical Clinic 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 into 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 collections services
  - The loss of patient privileges outside of emergency care.

I understand and agree to these guidelines:

____ ____________________________
Patient Signature *Date*

ONE CROSS MEDICAL CLINIC

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PAST MEDICAL HISTORY

Patient Full Name: ____ Date of Birth: ______________________

Are you currently taking any medications or drugs including natural supplements, herbs, OTC meds, and/or vitamins? Yes:__ No:__
If yes, please list: ____
____

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

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

Do you have any mental/special needs not listed? Yes:__ No:__ *If yes, what:*

Do you use tobacco products? Yes:__ No:__ *If yes, how often:*

Do you use alcohol? Yes:__ No:__ *If yes, how often:*

Do you use a controlled substance? Yes:__ No:__
If yes, please list: ____

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? Yes:__ No:__ *If yes, when/where:*

Have you received, or do you plan to receive, a pneumonia vaccine? Yes:__ No:__ *If yes, when/where:*

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

I have, to the best of my knowledge and ability, answered truthfully and accurately. I understand providing incorrect information may be dangerous to my (or my dependent's) health and it is my responsibility to notify this office of any changes.

______________________________ ______________________
Signature (Patient or Parent/Guardian) Date