Dr. Merit Lemke
Pinnacle Women's Health Center
9301 Connecticut Drive
Crown Point, IN 46307
219-796-4060

REGISTRATION FORM
(PLEASE PRINT)

Today's Date:___/___/___ Primary Care Physician:_____ Phone#_____

PATIENT INFORMATION

Patient's Legal Last Name: First: Middle:	Maiden Name:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐_____

Birth date: / /	Age:	Sex: ☐ Male ☐ Female	Marital Status (circle one): Single / Married / Div / Sep / Widowed	Spouse's Name:

Street Address:	Social Security Number:	Phone Number: ☐ Home ☐ Cell

PO Box:	City:	State:	Zip Code:

Occupation:	Employer Name and Address:	Employer Phone Number: ( )

INSURANCE INFORMATION

Name of Primary Insurance:	Policy Number:	Group Number:

Subscriber's Name:	Address:	Social Security Number:	Birth date: / /	Phone Number: ( )

Occupation:	Employer Name and Address:	Employer Phone Number: ( )

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, please explain:

Name of Secondary Insurance:	Policy Number:	Group Number:

Subscriber's Name:	Address:	Social Security Number:	Birth date: / /	Phone Number: ( )

Occupation:	Employer Name and Address:	Employer Phone Number: ( )

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, please explain:

IN CASE OF EMERGENCY

Name of Local Relative or Friend (not living at same address):	Relationship to Patient:	Phone Number: ( )	Work Phone Number: ( )

Pharmacy Name_____ Phone #_____ Mail Order____
Address:_____ City:_____ State____ Zip Code_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Pinnacle Women's Health Center. I understand that I am financially responsible for any balance. I also authorize Pinnacle Women's Health Center or Insurance companies to release any information required to process my claims.

Patient or Guardian Signature: X_____ Date:____/____/____

PINNACLE HOSPITAL
a physician owned facility

URGENT CARE
at Pinnacle Hospital

PINNACLE
MEDICAL GROUP

INSURANCE ASSIGNMENT AND RELEASE

I grant permission to Pinnacle Women's Health Center and any and all physicians who render my care, to administer such medical, surgical and diagnostic examinations, treatments, and procedures as deemed necessary for appropriate care. I understand that I am financially responsible to the Physician and/or Clinic for all charges incurred in the care and treatment. I authorize the release of all information as may be necessary for the completion of my insurance claims, and I authorize my insurance company to pay Pinnacle Women's Health Center directly. I understand that all over payment will be refunded. I understand that copay and any account balance will be paid prior to services being rendered. I understand that I am responsible for deductibles and balances which must be paid within 60 days of receiving the first statement from this office. **I understand that it is my responsibility to ensure provider** and LabCorp are in network with my insurance carrier.

Signature_____ Date:_____
(Patient/Parent of Guardian if under 18 years)

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Pinnacle Women's Health Center to use and disclose protected information (PHI) to carry out treatment, payment and health care operation (TPO). (The Notice of Privacy Practices provided by Pinnacle Women's Health Center describes such uses and disclosures more completely). I have the right to review the notice of privacy practices prior to signing this consent. Pinnacle Women's Health Center reserves the right to revise its notice of privacy practices at any time. A revised notice of privacy practices may be obtained by forwarding written request to:

Pinnacle Hospital
A physician owned facility
9301 Connecticut Drive
Crown Point, IN 46307

With this consent, Pinnacle Women's Health Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results, among others.
Please advise if there are any family members with whom we may leave messages or discuss your medical record with:

Name:_____ Relationship_____

Name:_____ Relationship_____

_____ (Initial)

With this consent, Pinnacle Women's Health Center may mail to my home or other alternative location any items that assist in the practice of carrying out TPO, such as appointment reminder cards and patient statements marked "Personal and Confidential". With this consent, Pinnacle Women's Health Center may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO. I have the right to request that Pinnacle Women's Health Center restrict how it uses or discloses my PHI to carry out TPO. _____ (Initial)

Email address:_____

I wish to enroll in the Patient Portal to obtain messages and test results _____ (Initial)
I understand that I will receive an email inviting me to join the portal.

I understand that if I do not wish to enroll in the Patient Portal, lab results can be accessed on LabCorp.com or by calling the office at 219-796-4060

The practice is not required to agree to my restriction, but if it does, it is bound by this assignment. By signing this form, I am consenting to allow Pinnacle Women's Health Center to use and disclose PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Pinnacle Women's Health Center may decline to provide treatment to me.

Signature:_____ Date:_____ Relationship to Patient:_____
(Patient/Parent of Guardian if under 18 years)

Print Patient's Name:_____ Print Name of Parent/Guardian: _____

ADMISSION AGREEMENT

1. Consent To Admission And Treatment

I voluntarily agree to the provisions of this **Consent** regarding my admission and treatment as a patient at Pinnacle Hospital (the "**Hospital**"). As part of the course of my care and/or diagnosis and treatment of my medical or surgical condition, I consent to the administration of medications, tests, procedures, services, items and hands-on care and to physical examinations (collectively "**Care**") by physicians practicing at the Hospital ("**Physicians**") and other Hospital personnel ("**Care Providers**"). I agree to follow all rules and regulations of the Hospital related to patient and visitor conduct and safety.

I understand that I may revoke this Consent at any time by providing written notice to the Hospital. My revocation will be effective upon receipt by the Hospital unless I specify a later date. However, I acknowledge that my revocation will not have any effect on any action taken by the Hospital in reliance on this Consent before the Hospital received my revocation. I understand that if I refuse to give this Consent or revoke this Consent, the Hospital may refuse to provide treatment to me where permitted by law.

2. Assignment of Benefits

The Hospital may agree to accept an assignment of my insurance plan benefits. If the Hospital agrees to such assignment, I acknowledge that my Care has been and/or will be rendered by the Hospital and my Physicians and/or Care Providers, and that I may be entitled to receive payment for my Care under one or more health insurance plan(s) ("**Insurance Plan(s)**") or any claim I might assert against others because of my injuries (my "**Claim**"). In consideration of my Care rendered or to be rendered for this admission and treatment and/or any subsequent related admission and treatment, including, but not limited to, inpatient, outpatient, or clinical visits, I hereby irrevocably assign and transfer to the Hospital all right, title and interest in all benefits or monies payable for Care rendered, including but not limited to: group medical, indemnity, self-insured or ERISA benefits or coverage; PIP; UIM/UM; auto or homeowner insurance. It is further agreed and understood that the obtaining of verification of benefits and/or pre-certification does not relieve me of any liability for the financial responsibility for goods and services provided or to be provided to me by the Hospital, Physicians and Care Providers. Even though I have assigned my rights under my Insurance Plans, I acknowledge that it is my responsibility to follow up with my Insurance Plan regarding payment if any claim related to my Care is not paid within forty-five (45) days of submission. I agree to execute all forms that the Hospital, my Physicians, my Care Providers or my Insurance Plan deem necessary or beneficial in order to enable the Hospital and my Physicians and/or Care Providers to apply for and obtain such payment. I agree that copays and balances are due at the time of service. Deductibles and balances must be paid within 45 days of receiving first statement. I understand that it is my responsibility to ensure provider and any service providers(LabCorp) are in network with my insurance plan

3. Assignment of Benefits for Medicare Beneficiaries

In consideration of my Care furnished by the Hospital, my Physicians and Care Providers, I assign to the Hospital, my Physicians and Care Providers payment of any Medicare benefits otherwise payable to me for my Care. I authorize any holder of medical or other information about me to release to Medicare and its agents and contractors any information needed to determine Medicare benefits or other benefits for my Care. I agree to execute all forms that the Hospital, my Physicians, my Care Providers or Medicare deem necessary or beneficial in order to enable the Hospital and my Physicians and/or Care Providers to apply for and obtain such payment.

4. Exposure of Hospital Personnel

If employees of the Hospital, students studying at the Hospital, my Physicians or any Care Providers (collectively, "**Hospital Personnel**") are exposed to my blood during the course of my Care (an "**Exposure**"), the Hospital may request that my blood or other body fluids be tested for the Human Immunodeficiency Virus ("**HIV**"), hepatitis, and/or other transmittable blood borne infections ("**Blood borne Infections**"). I have the right to refuse such a request and I have indicated (by checking the appropriate box below) my consent to such request for the tests or my refusal to consent:

☐ I consent to having my blood drawn to check for Blood borne Infections in case of an Exposure.

☐ I DO NOT consent to having my blood drawn to check for Blood borne Infections in case of an Exposure.

5. Personal Property and Valuables: Limitations on Liability

I acknowledge that the Hospital is not responsible for the loss of or damage to my personal property and that I am solely responsible for my personal property, including but not limited to, money, eye glasses, contact lenses, dentures, etc. I acknowledge that, if the Hospital permits, I may deposit personal property with the Hospital for safe storage in accordance with the Hospital's policy.

6. Acknowledgement of Notice of Privacy Practices

I acknowledge that I have received a copy of the Hospital's Notice of Patient Privacy Practices, which describes the permitted uses and disclosures of health information related to my Care by the Hospital, my Physicians and Care Providers.

7. Status of My Physicians or Care Providers

I understand that not all my Physicians and Care Providers practicing at the Hospital are employees of the Hospital, that non-employed Physicians and Care Providers provide service as independent contractors, and that the Hospital is not responsible for the Care provided to me by non-employed Physicians and Care Providers.

8. Advance Directives

☐ I DO have Advance Directives

☐ I DO NOT have Advance Directives

☐ I would like the Hospital to provide me with more information regarding Advance Directives

I acknowledge that I have had an opportunity to record with the Hospital my current preferences for Advance Directives by filing a new form or a copy of my previous Advance Directive and that the Hospital, my Physicians and Care Providers are not responsible for administering Advance Directives as to which the Hospital has not been expressly and properly notified.

9. Patient Rights

I acknowledge that I have been provided with a copy of the Hospital's Patient Rights information.

10. Disclosure of Physician Ownership in the Hospital or Pinnacle Healthcare LLC

I acknowledge that my signature on this form is evidence of my receipt of the following disclosure pertaining to a Physician's or medical practice's ownership or financial interest, or both, in the Hospital or Pinnacle Healthcare LLC. The following Physician(s) and/or medical practices maintain an ownership interest or financial interest, or both, in the Hospital or Pinnacle Healthcare LLC:

Name of Physician/Practice Dr. Merit Lemke, MD Pinnacle Women's Health Center

Address/City/State/Zip Code 9301 Connecticut Drive, Crown Point, IN 46307

Telephone Number 219-796-4060

I understand that I may choose to be referred to another facility or health care entity. For further information concerning such ownership interest, I understand that I can contact the physician or medical practice administrator at the addresses and telephone numbers shown above.

11. Guarantor Agreement

To the extent permitted by federal and Indiana law, the undersigned agrees that where he or she signs as the parent, spouse, legal guardian, legal representative, agent or other individual or entity, on behalf of the named patient ("**Patient**"), the undersigned individually guaranties payment of any and all Hospital, my Physicians and Care Providers charges incurred by the Patient during this admission and treatment or subsequent related admissions and treatments, including but not limited to, inpatient, outpatient, or clinical visits, at the Hospital. This is an absolute guaranty and it shall continue as long as any balance is still due and owing to the Hospital, my Physicians and Care Providers. The undersigned waives any exemptions from garnishment, attachment, or legal process in favor of Hospital, my Physicians and Care Providers to the extent permitted by federal or Indiana law.

Having read the above, I accept all the provisions of this Consent and my signature below is evidence of my acceptance.

Patient's Name (Please Print)	
Parent/ Legal Guardian's Name (Please Print)	
Patient/Parent/Legal Guardian's Signature	
Relationship if not the Patient	
Date and Time of Signature	☐ A.M. ☐ P.M.
Witness' Signature	
Name of Witness (Please Print)	

Name_____

DOB ____/____/____ Age_____ Martial status S M D W

Gynecological History

Number of pregnancies _____

Number of births_____ ☐ Vaginal ☐ C-Section

Contraceptive method

None____ Not Applicable____ Tubal Ligation____ Vasectomy____ IUD____ Rhythm____ Withdrawal____

Diaphragm____ Condoms____ Spermicide____ BCpatch/ring/pill____ Depo Provera____

Are your sexual partners Male ☐ Female ☐ Both ☐ None ☐

Please fill in the date of your last pap test and whether it was normal or abnormal

Pap Date_____ Normal ☐ Abnormal ☐

Have you ever had an abnormal pap? No ☐ Yes ☐ If yes, what year? _____

Mammogram Date_____ Normal ☐ Abnormal ☐ Never had ☐

Dexa Scan (bone density testing) date_____ Normal ☐ Never had ☐ Osteopenia ☐ Osteoporosis ☐

Menstrual History:

Last menstrual period:_____(first day of last period)

Age when you had your first period:_____

Date when you stopped having periods:_____ ☐ Not applicable

Menstrual Cycle: Days_____ Duration_____ Clots ☐ Yes ☐ No Painful periods ☐ Yes ☐ No

When was date of last colonoscopy_____ ☐ Never had

Illness/Medical conditions:_____

_____

_____

Please list all medication you are currently taking including current medical conditions:

Medication	Doses	How do you take?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any surgeries

Year	Procedure	Year	Procedure
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Risk Summary

Do you have a family history of:

_____ Heart Attack _____Heart Disease _____Breast Cancer _____Uterine Cancer

_____High Blood Pressure _____Diabetes _____Ovarian Cancer _____other cancer_____

Do you have a medical condition which requires you to take antibiotics at the dentist? ☐ Yes ☐ No

Do you have any allergies to drugs or medications? ☐ No ☐ Yes – please list below

Drug	Reaction	Drug	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you smoke? No Yes # of cigarettes per day_____

Number of alcoholic drinks per day_____ per week_____

Do you use recreational or illicit drugs? No Yes

Are you being abused or have you been abused? No Yes

Reason for your visit: _____

_____

_____

Please list any issues you would like to discuss:_____

_____

_____