PINNACLE HOSPITAL
Review of Systems

GENERAL:
- ☐ Fatigue/weakness
- ☐ Weight gain/weight loss
- ☐ Loss of appetite
- ☐ Fever / Chills
- ☐ Night sweats
- ☐ Trouble sleeping

EYES:
- ☐ Vision loss
- ☐ Blurry vision
- ☐ Double vision
- ☐ Drainage
- ☐ Redness

HEENT:
- ☐ Hearing loss
- ☐ Sinus pain
- ☐ Runny nose
- ☐ Ringing in ears
- ☐ Mouth sores
- ☐ Loose teeth
- ☐ Ear pain
- ☐ Nosebleeds
- ☐ Sore throat

NECK:
- ☐ Lumps
- ☐ Stiffness
- ☐ Pain
- ☐ Swollen glands

CARDIOVASCULAR:
- ☐ Chest tenderness
- ☐ Palpitations
- ☐ Chest pain
- ☐ Swelling of feet or legs
- ☐ Pain in legs with walking

RESPIRATORY:
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing
- ☐ Sputum production
- ☐ Coughing up blood

GASTROINTESTINAL
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Difficulty swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Blood in stool
- ☐ Change in bowel movements
- ☐ Incontinence- stool

GENITOURINARY:
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Urgency
- ☐ Blood in urine
- ☐ Incontinence- urine

MUSCULOSKELETAL:
- ☐ Joint pain
- ☐ Muscle pain
- ☐ Stiffness
- ☐ Swelling in joints
- ☐ Joint deformities/pain
- ☐ Back pain

SKIN:
- ☐ Rash
- ☐ Itching
- ☐ Lumps
- ☐ Change in existing skin lesion
- ☐ Hair / nail changes

BREAST:
- ☐ Pain
- ☐ Mass
- ☐ Nipple discharge
- ☐ Self exams

NEUROLOGIC:
- ☐ Headaches
- ☐ Weakness
- ☐ Seizures
- ☐ Numbness
- ☐ Tingling
- ☐ Dizziness
- ☐ Tremor
- ☐ Fainting

HEMATOLOGIC:
- ☐ Easy bleeding
- ☐ Easy bruising

ENDOCRINE:
- ☐ Heat or cold intolerance
- ☐ Frequent urination
- ☐ Excessive thirst
- ☐ Excessive sweating

PSYCHIATRIC:
- ☐ Memory loss
- ☐ Depression
- ☐ Nervousness
- ☐ Hallucinations
- ☐ Stress

Physician Signature _____ Date & Time _____

Patient Signature _____

pt sticker here

URGENT CARE
at Pinnacle Hospital

9301 Connecticut Drive • Crown Point, IN • 219.796.4150
www.PinnacleHealthCare.net

Doctor: _____

Clinic ☐ Urgent Care ☐
School/Sports Physical ☐

REGISTRATION FORM
(PLEASE PRINT)

Today's Date: ___/___/___ **Primary Care Physician:** _____

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:** ( )

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

Patient or Guardian Signature: X _____ **Date:** ___/___/___

Patient Label

PINNACLE HOSPITAL
a physician owned facility

URGENT CARE
at Pinnacle Hospital

PINNACLE
MEDICAL GROUP

INSURANCE ASSIGNMENT AND RELEASE

I grant permission to Pinnacle Express Care/Pinnacle Hospital 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 Express Care/Pinnacle Hospital directly. I understand that all over payment will be refunded. I understand that I am responsible for co-pays, deductibles and balances which must be paid within 60 days of receiving the first statement from this office.

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 Hospital 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 Hospital describes such uses and disclosures more completely). I have the right to review the notice of privacy practices prior to signing this consent. Pinnacle Hospital 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 Hospital 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. _____(Initial)

With this consent, Pinnacle Hospital 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". _____(Initial)

With this consent, Pinnacle Hospital 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 Hospital restrict how it uses or discloses my PHI to carry out TPO. _____(Initial)

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 Hospital 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 Hospital 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.

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 Copy provided Yes_____ No_____

Do we have the current Advance Directives Yes_____ No_____

Have there been any recent changes Yes_____ No _____

☐ 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

Address/City/State/Zip Code _____

Telephone Number _____

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

PINNACLE HOSPITAL

Acknowledgement of Payment Plan Interest Rate/Communication Consent

Dear Patient,

As a courtesy to its patients, Pinnacle Hospital has implemented a process whereby patients are given the option of making monthly payments on their account balances. In the event that you choose to enter such a payment plan, please be advised that you will have six months to pay off your account balance, in full; before you will be charged interest on your account. If you are unable to fully satisfy your balance in six months, you will be charged a one-time 8% interest on the remaining balance starting on the 7th month.

I also understand that the purpose of this agreement is to authorize the delivery of calls to me, including, but not limited to, using an automatic telephone dialing system or an artificial or prerecorded voice, or calls to a telephone number assigned to a paging service, cellular telephone service, specialized mobile radio service, or other radio common carrier service, or any service for which I am charged for the call (hereinafter "Authorized Communications"). I also understand that my agreement to the terms of the Prior Express Consent Form is not a condition of any Authorized Entity's willingness to provide services to me. To the extent permitted by applicable law, and without limiting any other rights the Authorized Entity's may have, I expressly consent and authorize the Authorized Entities to communicate with me for any reason, including reasons related to the services provided by Authorizes Entities or services to be provided in the future by the Authorized Entities, including collection of amounts owed for said services, via Authorized Communications at the telephone number or numbers I provide below, or that is provided on my behalf, or any phone number that any Authorized Entity obtains or finds on its own which is not provided by me. In addition, I further expressly consent and authorize the Authorized Entities to communicate with me via forms of SMS text messages, other forms of electronic messages, electronic mail, or other electronic communication sent or directed to me through any medium, no matter how the Authorized Entity obtain such contact information. Any Authorized Entity may communicate with me using any current or future means of communication, even if those means are not now known to the Authorized Entity or Consumer. I authorize any and all of the communication methods described in this paragraph even if I will incur a fee or a cost to receive such communications. I further promise to immediately notify the Authorized Entity if any telephone number or email address or other unique electronic identifier or mode of communication that I provided to any Authorized Entity changes or is no longer used by me. I agree that the consent and authorizations I have provided herein may be revoked only in writing addressed to the Service Provider and any authorized Entity. Finally, I understand that the Authorized Entities have relied upon my statements contain herein and on my promise to fulfill my obligations contained herein.

I hereby consent and authorize that a photocopy of this authorization may be considered as valid as the original.

I _____, a patient at Pinnacle Hospital, acknowledge and accept that I have read the information above and agree to the terms.

This Consent shall enure to the benefit of and be binding upon my heirs, agents, spouses, executors, administrators, successors, and assigns. I intend for all Authorized Entities to be third party beneficiaries of the consent I have provided herein.

_____ Date: _____

Patient

_____ Date: _____

Witness