Lawrence General Hospital

Patient Registration Form

Patient Information: (please print) Today's Date: _____

Legal Name: _____
Last First Middle

Birthdate: _____ Sex (circle one): M F U Social Security Number: _____

List Any Other Names Used: _____

Address: _____
Number Street City State Zip

Primary Phone Number: _____ Type: Cell / Home / Work

Alternate Phone Number: _____ Type: Cell / Home / Work

Marital status: Single / Married / Life Partner / Divorced / Legally Separated / Widow(er)

Religion: _____

Ethnicity (Please Circle): African / African American / American / Asian / Puerto Rican / Dominican / Other: _____

Race (Please Circle): American Indian / Asian / Black or African American / Hispanic / White / Other: _____

Language Spoken: _____ Need Interpreter: Yes / No Veteran Status: Veteran / Non-Veteran

Homeless: Yes / No Do you have an advance directive? Yes / No

Employment Status: Active Military / Disabled / Full-Time / Part-Time / Retired / Self-Employed / Student / Unemployed

Current Employer: _____ Occupation: _____

Employers Address: _____
Number Street City State Zip

Emergency Contact: Name: _____

Phone Number: _____ Type: Cell\ Home/Work Relation to patient: _____

- **Did you get hurt in a Car Accident or at Work? NO / YES**

Primary Care Physician: _____

Name of Provider Referring you to Therapy _____

Insurance Information:

Policy/ID # _____ Group # _____

Patient Relationship to Subscriber: Self / Spouse / Child / Other: _____

Subscriber Info (if not patient): Name _____ DOB: _____ Address: _____

Notice of Privacy Rights & Practices Acknowledgement Statement

We are required by a federal law known as "The Health Insurance Portability and Accountability Act" (HIPAA) as well as by Massachusetts law to maintain the privacy of your medical and health information, also referred to as "Protected Health Information" (PHI).

Our Notice of Privacy Rights and Practices describes how information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully. When we use or disclose your Protected Health Information, we are required to abide by the terms of the Notice (or any other Notice in effect at the time of the use or disclosure).

You have the right to request in writing that we restrict how Protected Health Information about you is used or disclosed. We are not required to agree to this restriction, but if we do, you will receive written confirmation of our agreement to which we will be bound.

Your signature below constitutes your acknowledgement that you have received a copy of our Notice of Privacy Rights and Practices, and your consent under Massachusetts law to the kinds of uses and disclosures of PHI mentioned in our Notice.

Patient's Signature: _____ Date: _____ Time: _____

Personal Representative: _____ Date: _____ Time: _____

Relationship to patient: _____

☐ Check if unable to obtain acknowledgement of receipt due to:

- ☐ Patient/personal representative refusal
- ☐ Patient incapacitation
- ☐ Other (specify): _____

To be filed in patient's medical record.

Written: April, 2003

Reviewed: April, 2010 | March, 2011 | February, 2018

Revised: April, 2010

Consent for Treatment

1. **Consent to examination, care, treatment:** I am presenting myself to Lawrence General Hospital (the Hospital) for admission, emergency services, and/or outpatient services, and I voluntarily consent to the examination, care and treatment performed by authorized Hospital agents, employees and medical staff, as may in their professional judgment be deemed necessary or beneficial, which may include, but is not limited to, laboratory testing, radiologic testing, diagnostic procedures, and/or surgical intervention. I acknowledge that no guarantees have been made to me as to the effect of such examination, care or treatment of my condition.

2. **Interpreter services:** Interpreter services are available at no cost to all patients who do not speak English or would like to communicate in an alternative preferred language.

3. **Use and release of information:** I authorize the Hospital and its employees, agents, and medical staff to use and release my medical information so that the Hospital may provide, coordinate and manage my health care services including case management, with my care providers including my Primary Care Physician and follow-up care Specialists and Non-LGH Specialists (community Physicians), conduct its health care operations, and seek payment from third parties for my treatment, or as required by law. I understand that laboratory reports and test results, including Human Immunodeficiency Virus (HIV) test results, if performed, are part of the Lawrence General Hospital electronic record, and will be available to my provider and others involved in my current and future treatment only. Other disclosures of these results or other sensitive information will require an additional authorization specific to the release of these conditions to be completed.

   I also authorize the Hospital's release of my medical information to insurers and providers outside of the Hospital when necessary so that these insurers and/or providers may treat me and/or seek payment for that treatment, and for the purpose of their health care operations, including the transmission of the minimally necessary medical and other information, consistent with LGH policies, via facsimile and/or electronic transmission, and hold LGH harmless from any and all claims that might arise from risks of accidental disclosure of medical information, which is inherent in facsimile and/or electronic communications, including electronic prescriptions to my pharmacy.

4. **Consent for blood borne pathogen testing and release of results:** If a Hospital staff member, physician, contracted clinician/technician, or other Hospital provider sustains an unprotected blood or body fluid exposure while caring for me, I authorize the Hospital to draw my blood (or use appropriate blood samples it may already have) for purposes of testing for HIV (the virus that causes AIDS), HBV (the virus that causes Hepatitis B) and HCV (the virus that causes Hepatitis C). I understand that neither my insurance company nor I will be charged for the tests. I understand that if my blood sample tests positive for HIV, HBV, or HCV, I will be notified by a physician and directed to my PCP for medical advice and counseling regarding my treatment and other choices, and that a healthcare professional will answer any questions I might have regarding the testing. I understand that the exposed staff member, physician contracted clinician/technician, or other provider has the right to know the results of my blood tests and will be provided with the results by the Hospital Employee Health Department.

5. **Assignment of insurance benefits and payment responsibility:** I understand that I am required to provide proof of medical insurance, often in the form of an insurance card, at each visit, should I expect coverage by insurance benefits. I authorize payment of my insurance benefits to the Hospital for services provided. I understand that I am financially responsible to the Hospital for all charges that are not covered by my insurance. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collections agency or attorney by the Hospital, I will be responsible for all reasonable costs of collecting monies owed, including court costs, collecting agency fees, and attorney fees. All delinquent accounts bear interest at the legal rate.

6. **Medicare/Medicaid Beneficiaries only:** I certify that the information given by me in application for payment under Titles XVIII and XIX under the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf for any services furnished to me by, or in, the Hospital, including physicians' services. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services any information necessary to determine these benefits or related services. I consent to the appropriate release of all medical records, including mental health records and records relating to any drug and/or alcohol abuse treatment to third parties should they be required to carry out necessary business functions with respect to Medicare and Medicaid.

Consent for Treatment

7. **Consent to photography:** I understand that any clinical photographs, video recordings or other digital images taken as part of my care and treatment will become part of my medical record.

8. **Personal belongings:** I am encouraged to leave all personal belongings at home. If I am unable to send my valuables home, I understand that the Hospital utilizes a locked safe for valuable belongings should I want them to be kept safe. ***I also understand that the Hospital is not liable for loss or damage to any monies, jewelry, documents, or items not placed in the Hospital's locked safe.***

9. **Sharing of your information: I understand that the Hospital maintains a directory for admitted patients** and may disclose to persons (such as family and friends, clergy, members of the media, law enforcement, and others who ask for me by name, (for the purposes of delivering mail or flowers, routing phone calls, and other communication purposes): (a) name; (b) room number; (c) general condition (i.e. limited condition report per Hospital policy); and (d) religious affiliation (disclosed only to members of the clergy).

   A. **Hospital Directory:** *I understand that to extent the Hospital is required by law to make a disclosure, the Hospital cannot adhere to any restriction to the contrary that I have requested.*

   ☐ I do not wish to be included in the Hospital Directory. _____ *Patient's Initials*

   B. **Notification of my location, general condition or death:** I understand the Hospital may disclose information about me to notify (or assist in the notification of) a family member, a personal representative, or another person responsible for my care, of my location, my general condition, and/or my death. This may include disclosure to public or private organizations authorized by law or charter to assist in disaster notification and relief efforts.

   ☐ I do not give my permission for the reasons described in Section B. _____ *Patient's Initials*

10. **Disclosures to individuals involved in my care:** I understand that I may permit the Hospital to disclose information about me to a family member, friend, or any other representative involved in my care, where the disclosure is directly relevant to that person's involvement with my care or payment for my care.

    ☐ I do not give my permission to use and disclose my health information to individuals involved in my care or payment for my care for the purposes described in this Section. _____ *Patient's Initials*

11. I understand that Lawrence General Hospital is a tobacco free environment.

12. **Acknowledgment of receipt of Notice of Privacy Practices:** I have reviewed the Hospital's Notice of Privacy Practices for additional details about how the Hospital may use and disclose protected health information about me.

    ☐ I hereby acknowledge receipt of the Lawrence General Hospital Notice of Privacy Practices.

I understand that this Consent Form is only valid for this date of service or for the duration of this current admission to the Hospital, ED or this series of outpatient visits and will automatically expire thereafter.

I have carefully read and understand the above, have had any questions explained to my satisfaction.

_____ _____ _____

Signature-patient or person authorized to consent for patient *(Relationship to patient)* *Date/Time*

_____ _____

Witness Signature *Date/Time* *2nd Witness Signature (if Verbal Consent)* *Date/Time*

Notice of Privacy Rights and Practices

(effective May 1, 2010)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY LAWRENCE GENERAL HOSPITAL AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

MEMBER ORGANIZATIONS: This Notice applies to services furnished at Lawrence General Hospital by the medical staffs, physicians, nurses, and other personnel of the following Lawrence General Hospital organizations/affiliates:

Lawrence General Hospital, Inc.; LGH Physicians Associates, P.C.; Community Medical Associates, Inc.; and Hospital-Based Groups.

Since April 14th, 2003, we are required under the Health Insurance Portability and Accountability Act (HIPAA) and Massachusetts law to maintain the privacy of your health information, to provide you with this Notice of Privacy Rights & Practices and follow the terms of our notice that is currently in effect.

This document explains in detail how we use and disclose your Protected Health Information (PHI). PHI is any information about you that could identify you and your past, present, or future physical or mental health condition(s). Your acknowledgement of receipt of this document is required the first time you receive services after April 14th, 2003, at one of the Lawrence General Hospital affiliates listed above.

Examples of how we can use and disclose your information without your authorization include:

Treatment – we keep a record of each visit and/or admission. These records may include your test results, diagnoses, medications or

other therapies. These records are used and disclosed to allow doctors, nurses, spiritual care and other health care and clinical staff providers who are involved in your medical care and need information to provide you with high quality care to meet your needs.

Payment – we maintain a record of and may use and disclose information related to, services and supplies you receive at each visit and/or admission, so that we can be paid by you, an insurance company, or a third party. We may tell your health plan and other payors about an upcoming treatment or service which requires their prior approval and authorization.

Health Care Operations – we use and disclose your medical information to improve the services we provide, to train staff and students, for business management, and for customer service purposes.

Your information may be shared amongst Lawrence General Hospital affiliates, other health care providers, third party payors and our Business Associates to facilitate treatment, payment or health care operations.

ADDITIONAL USES AND DISCLOSURES:

I. There are additional times when we are permitted or required to use/disclose medical information without your permission. These circumstances are listed below:

- In emergency treatment situations
- To assist incommunicative patients
- To protect victims of abuse, neglect or domestic violence
- For organ donations
- To Workers' Compensation if you are injured at work
- To coroners, medical examiners and funeral directors
- To a correctional institution if you are an inmate
- To avert serious threat to public health or safety
- If required by law
- For law enforcement
- For public health activities (tracking diseases or medical devices)
- For health oversight activities such as fraud investigations
- For certain judicial or administrative proceedings
- For government functions such as national security & intelligence
- For research following an appropriate review or waiver of authorization by an institutional review board to ensure protection of information

II. We may also use your information without your permission to:

- Recommend treatment alternatives
- Tell you about health benefits and/or services
- Send or call you with appointment reminders
- Ask you to make a charitable gift
- List your name, location, and general condition in the patient directory for the duration of your stay
- List your religious affiliation in the patient directory provided to clergy for the duration of your stay
- Communicate with those involved in your care

NOTICE OF PRIVACY RIGHTS & PRACTICES

WRITTEN AUTHORIZATION REQUIRED:

I. Except as otherwise permitted by law, all other uses and disclosures not described above will require your signed authorization. Most uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information require authorization.

You may revoke any authorization you provide at any time by delivering a written statement directly to the Privacy Officer, except to the extent that we have already taken action in reliance on your authorization.

II. Please know that federal and state law requires special privacy protections for certain highly confidential information about you including but not limited to: 1) confidential communications with psychotherapists, 2) mental health and developmental disabilities services, 3) alcohol and drug abuse prevention, treatment and referral, 4) HIV/AIDS testing, diagnosis or treatment, 5) venereal disease(s), 6) genetic testing, 7) mammography records, 8) research involving controlled substances,9) community mental health records. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

III. Your protected health information such as diagnosis, treatment, and nature of services, as well as demographic data, may only be used for fundraising purposes if your authorization is obtained. You have the right to opt-out of receiving any fundraising communications.

YOUR RIGHTS: Under HIPAA, you have the right to request in writing:

- restrictions on how we use or disclose your medical information.
- confidential communications in a certain manner or to an alternate location, phone or address other than your home.
- access to your medical information to review and obtain a copy, subject to federal and state laws (fees may apply); state law requires medical records to be retained for 20 years from your most recent episode of care.
- access to electronic copies of your Protected Health Information, and to have it sent electronically to a designated person.
- an amendment to your medical information if you feel you or your health care provider need to make additions or corrections.
- an accounting of disclosures of your medical information.
- a paper copy of this Notice even if you have received it electronically.
- revocation of any specific authorization obtained in connection with your privacy, such as for marketing and research.
- restricted release for services paid out-of-pocket that is not shared with your health insurance plan.
- to share information with your family, close friends or others involved in your care.
- to choose someone with medical power of attorney or your legal guardian to act for you.

While we will consider all requests for amendments and privacy restrictions carefully, we are not required to agree to any requested restrictions or changes.

OUR RESPONSIBILITIES: We are required by law to maintain the privacy of your medical information, to provide you with this written Notice of Privacy Rights and Practices, and to abide by the terms of the Notice currently in effect. We reserve the right to change this Notice and our privacy practices and make the new provisions effective for all information we maintain. Revised Notices will be posted in our facilities and offices, and will be available from your direct treatment provider. If affected, you have the right to be notified if a breach of unsecured protected health information were to occur.

FOR MORE INFORMATION: If you would like further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your PHI, you may contact our Privacy Officer at the address or phone number below. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Officer will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or with the Director. Lawrence General Hospital and its employees are committed to protecting patient privacy.

LAWRENCE GENERAL HOSPITAL PRIVACY OFFICER
Phone: 978-946-8111
Fax: 978-946-8191
maria.palumbo@lawrencegeneral.org

Written: April 14, 2003 Reviewed: April, 2010 Revised: April, 2010; September, 2013

Lawrence General Hospital
So good. So caring. So close.

Outpatient Rehabilitation Medical History Form

Name_____
Birth Date _____

Are you taking any Prescription or non-prescription medications? NO / YES **If Yes, Please list:**

Medication Name	Reason for Taking	Medication Name	Reason for Taking
_____		_____	
_____		_____	
_____		_____	

Do you have any Allergies? If yes, please List: _____

Have you ever had any of the following conditions or symptoms?

	NO	YES
Asthma/Bronchitis/Emphysema		
Chest pain/Shortness of Breath		
Heart Disease/Angina		
Pacemaker		
High/Low Blood Pressure		
Heart Attack/Heart Surgery		
Blood Clot/Emboli		
Stroke/TIA		
Parkinson's Disease		
Pins or Metal Implants		
Joint Replacement		
Diabetes		
Infectious Disease/ HIV / Hepatitis		
Cancer/Radiation		
Arthritis		
Osteoporosis		
Hernia		
Fibromyalgia		

	NO	YES
Kidney Disease		
Circulation Problems		
Anemia		
Epilepsy/Seizures		
Thyroid Condition		
Severe or Frequent Headaches		
Vision or Hearing Difficulty		
Dizziness		
Weakness/Energy Loss		
Recent Weight Gain/Loss		
Bowel or Bladder Problems		
Neck /Shoulder- Injury/Surgery		
Elbow/Hand- Injury/Surgery		
Back -Injury/Surgery		
Hip/Knee- Injury/Surgery		
Ankle/Foot - Injury/Surgery		
Other		

Has anyone hurt you physically or emotionally within the past year? NO / YES

Have you fallen within the last three months? NO / YES

Do you have a fear of falling? NO / YES

Do you currently have any of the following symptoms?
Fever, Diarrhea, Respiratory Illness or Rash with fever, or Draining Wounds NO / YES

Women Only: Is there any chance you could be pregnant? NO / YES

Patient / Guardian's Signature: _____ Date: _____