MR# _____ _____ HAR (Acct. #)_____

Patient Demographics

Name: (Last)_____ (First) _____ (M) _____

Sex: ☐ Male ☐ Female Date of Birth:_____ Social Security #: _____

Address: _____

Home Phone: _____ Work Phone: _____ Email: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Unknown ☐ Other _____

Employer: _____ Address: _____

Marital Status: ☐ SGL ☐ MAR ☐ SEP ☐ DIV ☐ WID ☐ UNK ☐ Sig Oth ☐ Oth

Primary MD: _____ Speciality MD: _____

Interpreter Needed: ☐ No ☐ Yes Preferred Language _____ Written Language _____

Race: _____ Religion: _____ Ethnicity: _____

Patient Contacts

Contact Name: _____

Relation to Pt: _____

Address Same as Pt? ☐ Yes ☐ No Address: _____

Home Phone: _____ Work Phone: _____

Guarantor/Responsible Party

Relation to Pt: ☐ Pt. ☐ Spouse ☐ Mother ☐ Father ☐ Guardian ☐ Other: _____

Guarantor Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Coverage Information

Plan 1: _____	Plan 2: _____
Insurance ID: _____	Insurance ID: _____
Group #: _____	Group #: _____
Group Name: _____	Group Name: _____
Billing Address: _____	Billing Address: _____
Member Effective To Date _____ Effective From Date: _____	Member Effective To Date _____ Effective From Date: _____
Subscriber : _____	Subscriber : _____
DOB: _____ SS# _____	DOB: _____ SS# _____
Relation to Pt: _____	Relation to Pt: _____
Employer: _____	Employer: _____
Employer Address: _____	Employer Address: _____
Auth/Precert #: _____	Auth/Precert #: _____
Tele # for Precert:	Tele # for Precert:

Accident Info

Accident Related ☐ Yes ☐ No _____ Accident Type: ☐ Auto ☐ Work ☐ Crime ☐ Other _____

Place: _____ Nature of Accident: _____

Payment Collected->amt $ ☐ Prepay ☐ Copay ☐ Deductible ☐ Deposit ☐ Not Covered/Self

Documents and Form completion information

Documents Collected:

☐ Photo ID

☐ Consent

☐ Insurance Card

☐ Other

Form Completed By: _____ Date Entered: _____

Entered in System by: _____ Time Entered: _____

Allegheny Health Network

Patient Identification

Patient Registration Downtime Form (Ambulatory)

Revised: 09/O5/2014

Part of Medical Record – File under _____ Tab

VAC: ☐ Pfizer ☐ Moderna ☐ J & J Booster: ☐ Pfizer ☐ Moderna ☐ J & J Dose 1:___/___/___ Loc:_____ Dose 2: ___/___/___ Loc:_____

COVID 19 Vaccine Registration Form

Name: _____ Cell: _____

Date of Birth: _____ Male__ Female__

Address: _____

Zip Code: _____

Race/Ethnicity: Caucasian African-American Asian

Hispanic Bi-Racial Other: _____

Have you ever been in a Covid vaccine trial? Yes No

History of severe allergies to vaccine or anaphylaxis? Yes No

History of Covid in the past 90 days? Yes No

(if yes, did you receive mono-clonal antibodies? Yes No)

Pre-existing health conditions/health history? Yes No

_____Clinic use only_____

Scheduled on: _____Time: _____

MLK CENTER

UECDC Quality of Life Learning Center

BTWC BOOKER T. WASHINGTON

Erie County Department of Health Public Health

MCIC

JFK

VAC: ☐ Pfizer ☐ Moderna ☐ J & J Booster: ☐ Pfizer ☐ Moderna ☐ J & J Dose 1:___/___/___ Loc:_____ Dose 2: ___/___/___ Loc:_____

Pediatric COVID 19 Vaccine Registration Form

Name: _____ Cell: _____

Date of Birth: _____ Male__ Female__

Address: _____

Zip Code: _____

Race/Ethnicity: Caucasian African-American Asian

Hispanic Bi-Racial Other: _____

Have you ever been in a Covid vaccine trial? Yes No

History of severe allergies to vaccine or anaphylaxis? Yes No

History of Covid in the past 90 days? Yes No

(if yes, did you receive mono-clonal antibodies? Yes No)

Pre-existing health conditions/health history? Yes No

Name of parent or legal guardian: _____

Signature of parent of legal guardian: _____

Date: _____

Home phone number of parent or legal guardian: _____

_____Clinic use only_____

Scheduled on: _____Time: _____

MLK CENTER

UECDC Quality of Life Learning Center

BTWC BOOKER T. WASHINGTON

Erie County Department of Health Public Health

MCIC

JFK JOHN F. KENNEDY CENTER INC.

This form applies to all of your inpatient, outpatient and physician office services within Allegheny Health Network (AHN).

CONSENT TO TREATMENT

I request those physicians and other health care professionals who care for me, to perform routine diagnostic procedures, hospital care and therapeutic treatments, which in their judgment, become necessary while I am a patient of the physicians and facilities of AHN. Routine diagnostic procedures and medical treatments include but are not limited to x-rays, physical therapy, blood tests and administration of medications and other diagnostic monitoring measures. I also consent to medical recording or filming necessary in the judgment of my physician, to document the course of my injury or illness and to provide appropriate medical care, performance improvement and education. I agree to have my photo taken for identification purposes. Where applicable to maternity cases, I acknowledge that a photograph of my newborn baby may be taken for security purposes.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations. I authorize the physicians and other health care professionals of AHN to retain, preserve and use for scientific, or educational purposes, or dispose of at their convenience, any specimens or tissue taken from my body during my hospitalization. If I undergo any procedure that requires the submission of tissue for pathologic examination, I authorize the use of any excess tissue for educational purposes.

I understand that AHN is an organized health care arrangement consisting of hospitals and primary and specialty care practices. Sharing my protected health information among its providers is essential for my care. I further understand that other community providers may also need to access my protected health information throughout AHN and with other community providers to allow for efficient care management and delivery.

By providing my phone number, I agree that the employees, agents, allied health professionals, contractors, or other representatives of AHN and its subsidiaries and affiliates, and/or any party contracted on their behalf, may contact me using automated dialing, pre-recorded script, interactive voice response, and/or text messaging technologies for health care related or account administration related communications, including but not limited to appointment and wellness reminders, results, or prescription refill notifications, care or benefit coordination activities, pre and post-operative or home health instructions, collection of financial liabilities owed, customer service or quality improvement operations, inquiries regarding participation in research studies, and/or for other non-telemarketing purposes. I understand that I may opt out of these types of communication methods without impacting my ability to receive care.

CONSENT TO TELEHEALTH ENCOUNTER

I understand that there are potential benefits of participating in telehealth, including care coordination, health management, and outcome improvement. If applicable, I hereby consent to a telehealth encounter for evaluation, diagnosis, and treatment. The telehealth encounter may occur with an off-site provider using two-way videoconferencing equipment, an online health questionnaire, secure messaging or other approved electronic means to transmit my health data. I understand that information used during this encounter may include my medical records and images, audio and video recordings, and output data from devices. I acknowledge that I have the right and opportunity to ask questions about this process.

I am aware that laws protecting the privacy and security of my health information apply to telehealth. I further understand that information will be transmitted over a secure network, and if stored, will be saved in a data repository protected by security protocols. I acknowledge that information obtained or recorded during the course of an encounter may become part of a designated record set, and I may request access to such information.

I acknowledge and accept that there may be risks associated with telehealth, including the quality of transmitted information, the ability to fully evaluate and diagnose certain conditions, delays in the encounter due to equipment limitations, and in rare cases, a security protocol failure. I acknowledge that alternative methods to telehealth may be presented to me if they are available, and I will have an opportunity to ask questions about such alternatives.

I acknowledge that I have the right to withdraw my consent to the use of telehealth, and will be advised of any impact to my care, such as treatment delay or potential cost related to transfer.

RELEASE OF RESPONSIBILITY

I understand that if I leave the facilities of AHN without the consent of the physician and / or fail to carry out instructions for follow-up care, I am doing so of my own free will. I further understand that any injury or harm I may suffer while away from the facilities of AHN will be entirely my responsibility. I further release the physicians, other health care professional agents, servants and employees of AHN from any claim by me or anyone on my behalf for the injuries or harm suffered while away from the facilities of AHN.

I understand that I am responsible for the security and whereabouts of any money, documents, personal items or other articles of unusual value unless such valuables are deposited with the appropriate office / personnel for safekeeping. All clothing, eyeglass

Patient Identification

Allegheny Health Network

201016

Consent to Treatment, Release and Acknowledgement

es, contact lenses, dentures, hearing aids, jewelry, cash or other personal property that I wish to keep with me while I am at an appointment or receiving treatment is at my own risk as to loss or damage. I release the physicians, other health care professionals, agents, servants, and employees of AHN from any liability whatsoever for lost articles and money that I might keep with me.

CONSENT TO APPEAL

In the event that my insurance company denies payment for any services rendered during this episode of care, I authorize the agents, servants, and employees of AHN to file a grievance for payment on my behalf; I understand that I have the right to rescind my consent to appeal at any time during the appeal process. If I consent to AHN filing a grievance on my behalf, I understand that I will not be able to file my own grievance concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing. This consent shall automatically be rescinded and I may file my own grievance if my health care provider does not file a grievance, or stops grieving my case. I understand that I am not required to agree to such Consent to Appeal and may opt out without affecting my ability to receive services.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the physicians, other health care professionals or AHN for any services furnished to me by that provider of service. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

STATEMENT TO PERMIT PAYMENT OF MEDICAID BENEFITS TO PROVIDER AND PHYSICIANS

I certify that the information given by me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Department of Public Welfare (D.P.W.) or its intermediaries or carriers any information needed for this or a related Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician or hospital/facility services to the physician or organization furnishing the service or authorize such physician or organization to submit a claim to D.P.W for payment.

ASSIGNMENT OF INSURANCE OR PAYOR BENEFITS

I recognize that I am primarily liable for payment for services rendered. In the event that I am entitled to medical care benefits or insurance of any type whatsoever, I hereby assign those benefits and my rights to insurance payment to physicians and AHN and any of its contract health care providers. I authorize physicians and AHN and the appropriate health care providers to apply for benefits and insurance on my behalf for services rendered to me. I certify that the insurance or other coverage benefit information supplied by me is correct, in accordance with applicable AHN, provider or insurance policies or agreements. If my insurance carrier requires pre-authorization for services I will receive, I understand that it is my responsibility to obtain the required pre-authorization. If I fail to do so, I will be liable for all or part of otherwise covered expenses.

ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT OF PHYSICIAN, HOSPITAL, FACILITY BILLS

I guarantee payment of all charges incurred for services rendered by the physicians, other health care professionals, and the facilities of AHN for the patient named on the opposite side of this page. The amount due for non-insurable charges including co-payment, deductibles, and private room fees shall all be paid in full at the time of service. Should my account be referred to an attorney for collection, I agree to pay reasonable attorney's fees and collection expenses.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of AHN's Providers Notice of Privacy Practices ("Notice"). I understand that information AHN acquires or creates about me will be disclosed to others for treatment, payment and health care operations or other appropriate purposes as set forth in the Notice or as authorized by me in writing.

I CERTIFY THAT I HAVE READ THIS FORM OR HAD IT READ TO ME AND UNDERSTAND ITS CONTENTS.

THIS CONSENT TO TREATMENT, RELEASE AND ACKNOWLEDGEMENT FORM WILL REMAIN IN EFFECT FOR A PERIOD OF ONE YEAR UNLESS I DECIDE TO REVOKE IT.

Signature_____ Date_____ Time_____

q Patient q Substitute Decision Maker

Signature of Witness_____ Date_____ Time_____

If Substitute Decision Maker, state relationship and reason:

Patient Identification

Allegheny Health Network

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Consent to Treatment, Release and Acknowledgement