Registration

Time In________ Time Out_________

Date of Birth _____/_____/_____ Age ____ Social Security Number _____ -- _____ -- ____

First Name __________________Middle _______________Last ________________________

Address____

City___________________________________ State___________________ Zip____________

Home Phone(____)____________Cell(____)___________ Gender(circle one) male female
Race________ Marital Status ________ Religion _________ Language Spoken_________

Employer Name__________________________Employer Phone(____)_________________

Address ________________________________ City____________ State ____ Zip ________
Employment Status: Full-time____ Part-time____
Reason for visit: Physical _____ Accident/Injury _____ Drug Screen______ Other________

Accident/Injury____

Date of injury ________________ Time of injury _________ Location __________________

How ____

Consent for Treatment: I hereby consent to the physicians, NP and/or the staff of Community Healthcare System Occupational Health Services to conduct such examinations, perform such procedures as are medically required, and administer such treatment and medication as deemed necessary or advisable, as ordered by the physician and/or NP during this episode of care. I am aware that the practice of medicine and surgery is not an exact science, and I hereby acknowledge that no guarantees have been made to me as to the results of such treatments, examinations, or medical procedures.
Release of Information: I hereby consent to Community Healthcare System Occupational Health Services, all physician(s) and/or NP providing services and any other authorized person, to release to its authorized billing agents, any physician who treated me, my insurance carrier, employer's workmen's compensation company, or other category of third party payer, the Social Security Administration under Title XVII (18) of the Social Security Act, the Professional Review Organization, or other intermediaries responsible for payment of my clinic charges a complete report of services rendered including diagnosis, findings and details of treatment and progress for the purpose of receiving payment of my event of care. I understand that any charges incurred on my behalf for work-related injuries shall be paid by my employer pursuant to the Indiana's Worker's Compensation Law and any required testing shall be paid for my employer. I understand that I am financially responsible for charges denied by my employer for injuries, employer paid services, determined not to be work related. I hereby authorize that this information may be disclosed to and used by the above named company.
Assignment of Benefits to Community Healthcare System Occupational Health Services: For medical services provided, I hereby assign, transfer, and set over to Community Healthcare System Occupational Health Services and physician and/or Nurse Practitioner who may have treated me, all my rights, title and interest to medical reimbursement. I further agree that I shall be responsible for any expenses paid by Community Healthcare System Occupational Health Services, including reasonable attorney fees, to collect amounts guaranteed.
HIPAA: I acknowledge that I **ACCEPT** □ **DECLINE** □ **PREVIOUSLY RECIEVED** □ a copy of Community Healthcare System Occupational Health Services' Notice of Privacy Practices in accordance with HIPAA regulations.
I authorize the release of any employment related physical exam or test results to the employer (who requested the evaluation).

X____ ___________________
Patient Signature **Date**

Toll-free: 866-835-0312
www.comhs.org/occ_health

□ ST. CATHERINE HOSPITAL
4321 Fir Street | Suite 313
East Chicago, IN 46312
Phone: 219-392-7424
Fax: 219-392-7450

□ ST. MARY MEDICAL CENTER
1354 South Lake Park Avenue
Hobart, IN 46342
Phone: 219-947-6495
Fax: 219-947-6408

□ St. Mary Medical Center
PORTAGE HEALTH CENTER II
3545 Arbors Street
Portage, IN 46368
Phone: 219-759-4604
Fax: 219-759-6580