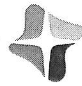
Reason for Visit: CT Lung Screening
DATE: ______________________
Location: Mobile Screening Bus
_____Grant
_____Insurance
_____Self Pay

FACE SHEET



CHI Memorial

Patient Information

Primary Care Physician: ______________________ Other Physicians: ______________________

Patient Name: ______________________ DOB: ______________ Age: ______ Sex: ______

Race: White Black Hispanic Other ______________ SS#: ______________ Height ________ Weight ________

Home Phone: ______________ Cell Phone: ______________ Traveled outside the US in the last 21 days: _____Yes ______No

Address: ____
Street/Apt. # *City* *State* *Zip Code*

Email Address: ______________________ Primary Language spoken if not English: ______________

Maiden Name: ______________________ Mothers First Name (security purposes): ______________

Marital Status: S M W D

Patient's Employer: ______________________ Full Time/ Part Time/ PRN______________

Address: ____
Street/Apt. # *City* *State* *Zip Code*

Work Phone: ______________ Ext: ________ Occupation: ______________

Emergency Contact: ______________________ Contacts Relation: ______________

Address: ____
Street/Apt. # *City* *State* *Zip Code*

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

If different than above: Next of Kin: ______________________ Relationship: ______________

Address: ____
Street/Apt. # *City* *State* *Zip Code*

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Are you currently participating in a Clinical Research Trial for which you have signed informed consent? _____ Yes _____No

Name of Physician managing trial: ______________ Where do you receive your Clinical Research Treatment? ______________

If you are not the primary insurance subscriber, Subscriber Name: ______________________ DOB: ______________

SS#: ______________ Employer: ______________ Company insurance is with: ______________

CHI Memorial

PATIENT DEMOGRAPHIC AND CONTACT INFORMATION
PREFERRED LANGUAGE

Thank you for choosing Common Spirit Health for your healthcare needs. We are collecting data regarding patient preferred language in order to improve the healthcare we provide to all patients. Our goal is to meet the needs of all the patients we serve in an effort to best provide services.

Please check the language you prefer to discuss your healthcare. If language services are requested, we will initiate that service request.

⑨ American Indian / _______
⑨ American Sign Language (ASL)
⑨ Amharic / አማርኛ
⑨ / cibarAكيارك
⑨ Armenian / [illegible]
⑨ Bantu / 幫手
⑨ Burmese / မြန်မာနိုင်c
⑨ Cantonese / 粵語
⑨ Certified Deaf Interpreter (CDI)
⑨ Chinese / 中文
⑨ Cushite
⑨ Dutch / Nederlands
⑨ English
⑨ French / Francis
⑨ French Creole / Créole Français
⑨ German / Deutsch
⑨ Gujarati / ગુજરાતી
⑨ Haitian Creole / Kreyòl ayisyen
⑨ Hindi / हिन्दी ⑨ Hmong / Hmoob
⑨ Ilocano / Pagsasao nga Ilokano
⑨ Italian / Italiano
⑨ Japanese / 日本
⑨ Karen / K'nyaw
⑨ Korean / 한국인
⑨ Kurdish / Kurdî
⑨ Laotian / ພາສາລາວ
⑨ Mandarin /普通话
⑨ Mixteco / Mixctli
⑨ Mon-Khmer Cambodian / ខ្មែរ
⑨ Nepali / नेपाली
⑨ Norwegian / Norsk
⑨ Pennsylvanian Dutch / Pennsylvania Nederlands
⑨ /)israF(naisrePيسراف يسراف
⑨ Polish / Polskie
⑨ Portuguese / Português
⑨ Punjabi / ਪੰਜਾਬੀ
⑨ Romanian / Română
⑨ Russian / русский
⑨ Samoan / Samoa
⑨ Serbo-Croatian / српски хрватски
⑨ Spanish / Española
⑨ Swahili / Kiswahili
⑨ Filipino / Tagalog
⑨ Thai / ไทย
⑨ Ukrainian / український ⑨ / udrUودرا
⑨ Vietnamese / Tiếng Việt ⑨ Yoruba / Yoruba ⑨ Other:

CHI Memorial

PATIENT IDENTIFICATION

PATIENT DEMOGRAPHIC AND CONTACT INFORMATION

We are collecting data regarding patient race and ethnicity in order to improve our healthcare we provide to all patients. Our goal is to meet the needs of all the patients we serve. We can better meet the needs of our communities that we serve if we know more about our patients' race and ethnicity.

This information will only be used to ensure that all patients are receiving appropriate care of the best quality.

Please check the appropriate responses below:

RACE **ETHNICITY**

⑨ African American/Black ⑨ Hispanic/Latino(a)
⑨ Native American/Indigenous ⑨ Non-Hispanic/Latino(a)
⑨ Native Hawaiian or Pacific ⑨ Unknown
⑨ Islander ⑨ Prefer not to answer / Decline
⑨ White
⑨ Asian or Asian American
⑨ Two or More Races
⑨ Unknown
⑨ Prefer not to answer / Decline
⑨ Other

EMAIL ADDRESS

In order to ensure we are providing you with exceptional service we would like to be able to contact you after your visit. Please provide your current contact information below. Patient Portal access is only available through email communication. Should you wish to utilize this service, please provide a valid email address. Also, you may receive a survey about the services provided throughout your stay, we appreciate your response so we can provide the best experience possible when you return.

Email Address (please print):

______________________________________@______________________.______________

⑨ I decline to provide an email address ⑨ I do not have an email address

Mobile phone number:

(_____)_________-______________

Home phone number:

(_____)_________-______________

____

Patient / Patient Representative Signature

____

Date

PATIENT IDENTIFICATION

CHI Memorial

181103

Patient Identification

CONDITIONS OF ADMISSION AND GENERAL CONSENT FOR TREATMENT

1. **<u>CONSENT TO TREATMENT</u>.** The undersigned recognizes that there are risks and hazards incident to any medical procedure, and that there is no guarantee that any particular treatment will be successful. Except in emergency situations, it is the attending physician(s)'s responsibility to adequately inform the patient or the patient's representative concerning a proposed treatment, and to obtain the consent of the patient or his representative before proceeding. The patient has the right to question and refuse treatment, however, should the patient refuse the proposed treatment, he/she thereby releases the physician and the hospital from any liability. The undersigned hereby consents to any radiological examination including those using intravenous or oral contrast, nuclear medicine stress test, laboratory procedures, anesthesia, medical or surgical treatment, hospital services, and such routine tests or procedures as directed under general or special instructions of the physician. Further informed consent may be necessary. I authorize medical records and/or billing information may be faxed or e-mailed to health care providers when needed for continuity of my care and/or to any insurer, entity, or health care benefits program that might be responsible for payment.
2. **<u>TESTING FOR INFECTIOUS DISEASES</u>:** If a health care provider or first responder (such as an emergency worker, fire fighter or police officer) is exposed to my bodily fluids, I consent for the Hospital to test my blood for HIV or other infectious diseases transmitted by bodily fluids. Information concerning the fact that a test was ordered and the results of such test will remain confidential and be disclosed by the Hospital only as permitted by law.
3. **<u>PATIENT'S PHYSICIANS</u>.** The patient is under the control of his/her attending physician(s). The undersigned understands that he/she may receive medical care from doctors whom he/she does not specifically request or even know, such as in the Emergency Center or consultations requested by a physician. The undersigned recognizes that dentists, endodontists, oral surgeons, and ~~all~~ doctors of medicine, including the radiologist, pathologist, anesthesiologist and Emergency Center physicians and Emergency Center mid-level practitioners who furnish services to the patient and do not work for the hospital, but are private health care providers will bill separately for their services and make decisions regarding the patient's diagnosis and treatment. Hospitalists and Intensivists work for the hospital and will therefore not bill separately. The undersigned understands that the hospital is not liable for any act, judgement, or treatment by the physician or any act, care, or treatment by the hospital while following the instructions of the patient's attending physician(s).
4. **<u>DOCUMENTATION OF PATIENT CARE</u>**. I understand that the Facility or persons on its behalf may make photographs, videotapes, digital, or other images or audio recordings to document my care, to assist in my care, to use in education of those involved in patient care and to otherwise advance quality of care or service at Memorial Health Care Systems; and I consent to this. I understand that CHI Memorial will retain the ownership rights to these photographs, access to view them or to obtain copies. I understand that these images will be stored in a manner that will protect my privacy. Images that identify me will not be released or used outside CHI Memorial absent specific written authorization from me or my legal representative.
5. **<u>AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION</u>.** I authorize the hospital to release to any person, corporation, or other entity any diagnostic and therapeutic information (including any treatment for alcohol or drug abuse and any psychiatric or psychological treatment) as may be necessary to determine health care benefits entitlement for this patient under any insurance policy or other type of health care benefits plans or as may be appropriate for the purpose of analysis or research regarding reimbursement of doctors and other health care providers. I authorize the hospital to process payment claims for health care services provided to the patient. I agree to cooperate and execute such other authorizations and releases for the above purposes as deemed necessary by the hospital upon the hospital's request. This organization may utilize information in my medical record that is necessary for research for quality improvement purposes.
6. **<u>ASSIGNMENT OF INSURANCE BENEFITS AND DESIGNATION OF AUTHORITY</u>.** The patient and/or guarantor hereby assigns to the hospital all the rights, claims, and interest which he/she may have against any insurer, entity, healthcare benefits plan program, or which the patient may have against any third person and/or their insurer or an uninsured motorist carrier that may be responsible or liable for payment for the injuries for which the patient received services and authorizes the hospital to collect by assignment on any claim against said person, insurer, entity, or healthcare benefits plan or program, including filing suit in the name of the patient and/or guarantor, in an attempt to recover benefits due for treatment rendered at the hospital. Patient and/or guarantor understand that the hospital may waive any and all rights granted herein and elect to proceed solely against the patient or guarantor personally, for the services rendered on the patient's behalf. The undersigned authorizes and directs said insurance company, entity, plan, or program administrator to furnish the hospital with all information regarding the patient's benefits, claim status, reasons for non-payment, and other information deemed necessary by the hospital. If this admission to the hospital is a result of a work-related injury, see Worker's Compensation Authorization.
7. **<u>PERSONAL VALUABLES</u>**. It is understood and agreed that the hospital maintains a safe for safekeeping of valuable personal property, such as money, jewelry, watches, etc. It is recommended not to bring or keep valuable personal property or personal/home medications at the hospital. The hospital shall not be liable for the loss of or damage to any personal property, unless deposited with the hospital for safekeeping.
8. **<u>MEDICARE BENEFITS</u>.** If the patient is covered by Medicare, the undersigned certifies that the information given in applying for payment under Title XVIII of the Social Security Act is correct. The undersigned authorizes any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. The undersigned requests that payment of authorized benefits be made on the patient's behalf. The undersigned assigns the benefits payable for physician services to the physician or organization furnishing the services or authorizes such physician or organization to submit claim to Medicare for payment to the patient.

CHI Memorial

CONDITIONS OF ADMISSION AND GENERAL CONSENT FOR TREATMENT

9. **WORKERS' COMPENSATION AUTHORIZATION.** If my admission to the hospital is a result of a work related injury, I hereby waive any privilege I may have with any physician, psychiatrist, chiropractor, hospital, or other healthcare provider, and I hereby authorize such healthcare provider to provide the worker's compensation administrator for this facility, any information, including, but not limited to, a right to inspect and copy all records, x-rays, x-ray reports, medical charts, or prescriptions, reasonably related to my injury or to my past relevant medical history. A copy of this form may be accepted in lieu of the original. In the event there is a dispute about the compensability of my claim for worker's compensation benefits, and if my employer is not specifically determined by a Court or the Department of Labor to be responsible for worker's compensation medical expenses for the condition or injury that is the basis of my admission, I agree to be personally responsible for all such expenses. I further agree that if my worker's compensation claim is settled with my employer on a disputed basis without a specific finding that such is compensable as a worker's compensation injury, I (or my attorney if I am represented), will withhold sufficient funds from any settlement to pay all amounts owed to the hospital for treatment of the condition which is the basis for this admission; and I hereby grant an assignment to the hospital for payment of all such expenses under such circumstances.

10. **PAYMENT GUARANTEE.** The undersigned agrees, whether he or she signs as a patient, as patient's guardian, as patient's agent, or representative, or as guarantor on behalf of patient, that in consideration of the services rendered to the patient, he or she and/or guarantor hereby individually obligate themselves to pay the account owed by the patient to the hospital. Should the account be referred to a collection agency or an attorney for collection, the undersigned shall pay reasonable attorney's fees and/or collection agency fees, and all other costs of collection, including court costs. The undersigned further authorizes the transfer of any overpayment on this account to be applied to any accounts on which the undersigned is a patient, guarantor, or otherwise legally responsible.

11. **COMMUNICATIONS CONSENT:** By providing my cell, landline, or any other number(s), I expressly consent to receiving communications from Hospital, its staff, its contractors, collection agents, and others, at any numbers I provide or that are later acquired for me. These parties may use this information to contact me by live agent, voice mail, text message, using an auto dialer or other computer assisted technology, pre-recorded message(s), or by any other form of electronic communication for any purpose including, but not limited to, appointment and follow-up health care reminders, scheduling, my account(s), assignment of benefits, and/or financial responsibility. I understand that depending on my phone plan I could be charged for these calls or text messages. I agree to provide new number(s) if my number(s) change. Providing these numbers is not a condition of receiving healthcare services.

12. **TELEHEALTH**: I understand that techniques of telemedicine may be employed to facilitate patient care. Techniques include but are not limited to, electronic transmission of radiographic images (x-rays), remote access to laboratory results, electronic transmission of vital signs, visits by my physician via IPad or smartphone/tablet device, bedside video imaging of patients, and/or remote monitoring of life support equipment. Telehealth technology may also include, but not be limited to, for the use of diagnostic, treatment, education and follow-up visits.

I, the undersigned, declare and represent that I have read this document, understand it, and that any questions have been answered to my satisfaction. The undersigned further certifies that he/she is the patient or is duly authorized by the patient as the patient's general agent or representative to execute the foregoing and accept its terms.

_______________________________ _________ _________
(Patient Signature) *(Date)* *(Time)*

____
(Print Patient Name)

_______________________________ _________ _________
(Agent, Representative, Spouse Signature) *(Date)* *(Time)*

_______________________________ _______________________________
(Print Patient's Agent, Representative, Spouse Name) *(Print Relationship to Patient)*

_______________________________ _________ _________
(Witness Signature) *(Date)* *(Time)*

_______________________________ _________ _________
(Guarantor Signature) *(Date)* *(Time)*

CHI Memorial does not discriminate on the basis of race, color, national origin, sex, religion, age or handicap status in employment or the providing of services.

Date:________________ **Patient Name**:____________________________

_________________ **DOB**: _______________

COVID QUESTIONNAIRE

1. Have **you** ever been diagnosed with COVID-19? **Yes/No** If Yes,When? _______

2. Have **you** had a COVID-19 Vaccine? **Yes/No** **If Yes, List below:**↓↓↓↓↓

(Please circle which arm):

a**. FIRST DOSE** : RIGHT ARM / LEFT ARM Date received_____________

b**. SECOND DOSE**: RIGHT ARM/ LEFT ARM Date received_____________

c**. BOOSTER**: RIGHT ARM/ LEFT ARM Date received_____________

d. **BOOSTER**: RIGHT ARM/LEFT ARM Date received_____________

PAST MEDICAL HISTORY

Have **you** had any of the following: **Please Circle (Yes or No)**

Breathing/Lung Disorders? Asthma? **Yes/No** COPD? **Yes/No** Emphysema? **Yes/No**

Chest/Breast/Lung Surgery? **Yes/No** Type:______________________________

Heart Stents? **Yes/No** Heart Bypass Surgery? **Yes/No**

Have **you** ever been diagnosed with Cancer? **Yes/No** Type:__________________

Family History of Cancer:

Father: Type:____________________________

Mother: Type:___________________________

Brothers: Type:__________________________

Sisters: Type:____________________________

Do you take a statin (Example: Crestor, Lipitor, Atorvastatin) for Cholesterol? Yes/ No