DRH HEALTH CLINICS
New Patient Information

Date: _____

Duncan Regional Health Clinics look forward to meeting your healthcare needs. To best determine how to meet your needs, we need to know about the condition which brings you here. Please list all the medications you are currently taking, including over-the-counter medication. Your healthcare provider will review all of this information, and then you will be contacted regarding an appointment.

** We will not be able to accommodate patients who only have pain management needs. **

Requested Provider if available: _____

DRH HEALTH CLINICS
New Patient Information

Patient Full Name _____

Date of Birth _____ Male ☐ Female ☐ Decline to specify ☐

Marital Status _____ Social Security # _____

Race _____ Ethnicity ☐Hispanic ☐Non-Hispanic

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

E-mail _____

How did you hear about us? _____

Guarantor Name (if minor) _____

Guarantor Date of Birth _____

Relationship to Patient _____

Patient's Employer _____

Employer Address _____

Emergency Contact _____ Phone Number _____

Please provide a copy of your insurance card(s) to the front desk for scanning.

☐ Commercial
☐ Medicaid
☐ Medicare
☐ Medicare Advantage
☐ Other
☐ Self Pay

☐ I authorize the DRH Health provider and designated employees to access the Oklahoma Prescription Monitoring Program database to review my information

_____
Your Signature Today's Date

DRH HEALTH

DRH HEALTH CLINICS
New Patient Information

Medical Information

What brings you in today? _____

Current Health Diagnoses	Past Medical History	Surgical History

Allergies to Medications: _____

What Pharmacy do you prefer to use? _____

Current Medication

Please include any over the counter medications and supplements

Name of Medication	Dosage, Frequency and Route

Authorization for Release of Medical Records

To: _____

_____

_____

_____

I, _____ being competent, eighteen (18) years of age or older and duly authorized, do willfully and voluntarily authorize you to release medical records to Duncan Regional Health.

** Please see fax cover sheet for address, phone & fax number.

On ☐ myself ☐ other _____ the complete medical record in your possession concerning overall health care, illnesses and treatments administered for the time period _____ to _____. I release you from all legal responsibility or liability that may arise from this authorization.

I further understand and acknowledge that the Information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may Include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea and the Human immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Signature of Patient or Guardian _____ Date _____

Date of Birth _____ Social Security Number _____

Patient's Address _____

Patient's Phone Number _____

Note: If the patient is a minor or otherwise incapacitated, law requires that the legally authorized guardian or custodian authorize or consent to the release of such medical information.

AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name _____ Date of Birth _____

I authorize DRH Health to share or release the protected health information (PHI) listed below to the following individuals or organizations. These individuals can be contacted to assist in scheduling visits, tests and procedures:

1. Name _____ Address _____ Phone _____
PHI to be shared: ___ Medical Record ___Mental Health Records ___Substance Abuse Records ___Billing Information

2. Name _____ Address _____ Phone _____
PHI to be shared: ___ Medical Record ___Mental Health Records ___Substance Abuse Records ___Billing Information

3. Name _____ Address _____ Phone _____
PHI to be shared: ___ Medical Record ___Mental Health Records ___Substance Abuse Records ___Billing Information

4. Name _____ Address _____ Phone _____
PHI to be shared: ___ Medical Record ___Mental Health Records ___Substance Abuse Records ___Billing Information

5. Name _____ Address _____ Phone _____
PHI to be shared: ___ Medical Record ___Mental Health Records ___Substance Abuse Records ___Billing Information

The above individuals/organizations can receive ___Verbal and Printed PHI ___Verbal PHI ___Printed PHI

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made at DRH Health and will not affect information that has already been disclosed.
- I have a right to receive a copy of this authorization.
- I understand that unless the purposes of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- I understand my medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time at DRH Health, in person or in writing.
- I understand that this authorization for release of PHI from DRH Health is valid for all DRH entities and affiliates, including: Duncan Regional Hospital, Jefferson County Hospital, Duncan Regional Imaging Center, and all DRH Health clinics.
- I understand it is my responsibility to revoke or change this authorization when needed.
- I understand I cannot restrict information that may have already been shared based on this authorization. Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's expiration date will be:

___2 years from today ___No expiration (lifetime) _____ Other _____

If I am hospitalized, family members and friends who wish to obtain verbal updates on my current condition will still be required to provide the 4-digit "Pass Code" that is given to me at the time of my hospital admission.

_____ _____
Signature of Patient or Legal Representative Date

_____
Description of Legal Representative's Authority

PATIENT RIGHTS AND RESPONSIBILITIES

As a natural outgrowth of our belief, values and mission, we recognize the following rights and responsibilities of patients:

- Patients have a right to quality health care which Includes consideration and respect for the physical, psychosocial, spiritual, educational and cultural variables that influence their perceptions of illness. They have a right to expect reasonable continuity of care and assistance in locating alternate services when medically indicated. Patients have a responsibility to take care of their health as best they can.
- Patients have a right to information at the time of admission about the rules and regulations that apply to patient care and conduct and the hospital's policies related to patient rights and responsibilities. Additionally, they have a right to information regarding the mechanism for initiation, review and, when possible, resolution of patient complaints concerning the quality of care. Patients have a responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, and medication relating to their health care.
- Patients have a right to expect the hospital to make a reasonable response to their request for services consistent with the hospital's obligations, policies and moral religious beliefs, within the hospital's capacity, its stated mission and applicable law and regulation. Patients have a responsibility for making health care decisions that affect their life.
- Patients have the right to receive services on a non-discriminatory basis without regard to race, religion, color, sex, national origin, age, disability, or any other classification prohibited by law, Patients and their families should express any needs they may have to enable us to provide reasonable accommodations.
- Patients have a right to personal privacy and confidentiality of information, All patients and/or their legally designated representative have a right to access their medical record within a reasonable time frame. Patients have a responsibility to respect the privacy and confidentiality of other patients within the hospital and follow the rules that apply to patient care and conduct.
- Patients have a right to have a family member or representative and their own physician notified promptly of their admission to the hospital. Patients have a responsibility to inform their nurse if they want a family member or physician to be notified of their admission.
- Patients have a right to have personal possessions reasonably protected. Patients are asked to leave valuables at home or deposit in the hospital's safe during hospitalization.
- Patients have a right to receive care in a safe, secure setting and to be free from all forms of abuse, neglect or harassment. Patients have a responsibility to inform the health care team when they have issues or concerns related to their safety.
- Patients have a right to assistance in obtaining protective services. Patients have a responsibility to inform the health care team when they have issues or concerns related to their safety.
- Patients have a right to be free from seclusion or restraints of any form that are not medically necessary. Patients and their families have a responsibility to assist the health care team in maintaining the patient in the least restrictive environment.
- Patients or their designated representative have a right to be informed of and participate in their care planning process and treatment decisions. Patients have a right to be informed of alternative treatments and to choose among the alternatives, including a right to accept or refuse treatment to the extent permitted by law, and to be informed of the medical consequences of their actions. Patients have the responsibility of cooperating in the treatment plan that has been decided.
- Patients have the right to appropriate assessment and management of pain. Patients are expected to inform the health care team when experiencing pain or when the pain relief plan is not working.

- Patients or a designated representative have a right to participate in the patient's discharge planning, including being informed of service options that are available to the patient and a choice of agencies that provide the service. Patients have a responsibility for making health care decisions that affect their life.
- Patients have a right to formulate advance directives and to appoint a surrogate to make health care decisions on their behalf to the extent permitted by law. Patients have a responsibility to inform the health care team of the existence of an advance directive and the intent contained therein.
- Patients have a right to be informed about the outcomes of care, including unanticipated outcomes. Patients are encouraged to ask questions so that they may understand what to reasonably expect during their course of treatment.
- The patients guardian, next-of-kin or legally authorized responsible person has a right to exercise the rights delineated on behalf of the patient if the patient lacks the capacity for participating in the decision-making process. If a patient is unable to participate in the decision-making process, then the patient's guardian, next-of-kin or legally authorized responsible person has a responsibility to make health care decisions consistent with the patient's values and life goals.
- Patients have a right to participate in the consideration of ethical issues that arise in their care. Patients have a responsibility for making health care decisions that affect their life.
- Patients have a right to be informed of any human experimentation or other research educational projects that may affect their care or treatment. Patients are responsible for their own actions If they refuse treatment or do not follow the physician's or primary caregiver's recommendations.
- Patients have a right to examine and receive an explanation of their bill, regardless of the source of payment. Patients have a responsibility to provide information necessary for claims processing and to be prompt in payment of bills.

If you do not believe that we have honored all of the rights outlined above and would like to express any concerns regarding this, please contact Patient Relations at 580-251-6897 or in writing at Patient Relations, 2621 Whisenant Drive, Duncan, OK 73533. The Patient Relations office will assist the Individual, facilitate the investigation of any complaints and respond to the patient.

Medicare Shared Savings Program
Accountable Care Organizations

Working together to give you the best care.

Duncan Regional Hospital/Jefferson County Hospital/Solutions Physician Practice Management

is part of an Accountable Care Organization (ACO), We've teamed up with other doctors, hospitals, and health care providers to make sure you get the best care.

We provide coordinated car for you to get well & stay well

- You get patient-centered care focused on YOUR needs.
- Your health care providers can see the same test results, treatments, and prescriptions.
- More coordination helps prevent medical errors and drug interactions.
- You may save time, money, and frustration by avoiding repeated tests and appointments.
- Better communication can help protect against Medicare fraud and waste.

You may have access to expanded benefits

- We may offer telehealth services which let your primary care doctor care for you without an in person visit, no matter where you live.
- Ask your health care provider if you qualify for these benefits.

Get the most from your care with our communication & support

- **Ask about signing up for our secure online portal.** You'll get 24-hour access to your personal health information, including lab results and communication from your health care provider.
- When you choose a health care provider that participates in an ACO, they'll help you get the right care at the right time. You can visit **Medicare.gov** and log into (or create) your secure Medicare account to choose a primary care doctor.
- Medicare protects the privacy of your health information. If you don't want Medicare to share information with your health care providers for care coordination, call 1-800-MEDICARE (1-800-633-4227). Medicare may still share general information to measure provider quality. For more information on how Medicare may use and give out your information, visit Medicare.gov and search for "privacy."

Want more information?

Ask our front desk, or call us at our office phone. You can also visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
To report a Medicare-related concern or complaint, call 1-800-MEDICARE (1-800-633-4227).
Learn more about Accountable Care Organizations here:

CMS MEDICARE SHARED SAVINGS PROGRAM