Fairview Hospital
a Cleveland Clinic hospital

CENTER FOR FAMILY MEDICINE
18200 Lorain Avenue
Cleveland, OH 44111
(216) 476-7088
(216) 476-7323 (facsimile)

www.fairviewhospital.org

Dear New Center for Family Medicine Patients,

Thank you for your interest in the Center for Family Medicine! Established in 1976, the Center for Family Medicine provides high-quality, affordable and convenient primary medical care for people of all ages. We are eager to provide your family with our full range of primary care services.

The Center for Family Medicine is the office practice for the Fairview Hospital/Cleveland Clinic Family Medicine Residency Program. Our physician staff includes 18 resident physicians, six full-time physician faculty and a family nurse practitioner. All of our residents are fully qualified medical school graduates (with MD or DO degrees) who are specializing in Family Medicine. Generally, patients enrolling at the Center for Family Medicine will be assigned to a resident physician who will be their primary doctor. All care at the Center for Family Medicine is provided under the supervision of the faculty physicians. Our faculty physicians are "participating providers" with many insurance companies, and any services provided at the Center for Family Medicine will be covered under those plans. Our large physician staff allows us to offer extended and weekend office hours as well as many ancillary providers (behavioral scientist, patient education nurse, nurse practitioner, etc.) to make your care more accessible and comprehensive. See the enclosed brochure for the full description of our services — and keep it handy for future reference!

Enclosed is our Enrollment Packet that you requested. It includes one **Family Enrollment Form** and several **Medical History Forms** (one for each family member you wish to enroll). It is vital that we have the basic medical history information and the **Release of Medical Information Form** for each family member so that we can provide high-quality care to your family when it is needed. By completing these forms, you are giving us the necessary information to enter your family into our computer system and put together medical record charts for each family member so that we are prepared to serve you when necessary. **Please provide a copy of each side of all your insurance cards.** A postage-paid envelope is enclosed for your convenience.

Once you have returned your Enrollment forms to us, our office will process these promptly and you will be able to schedule appointments as necessary. Your prompt response in returning these forms will assure that we are able to begin care for your family as soon as possible.

Again, thank you for your interest in the Center for Family Medicine. We look forward to serving you.

Sincerely,

Denise Stamper
Front Office Supervisor

Fred M. Jorgensen, MD
Medical Director

CFM 01/95, Last Revision 05/09

Center for Family Medicine – Patient Enrollment Form

Please print ***Please complete all applicable spaces on form***

PATIENT INFORMATION

Name_____ Date of Birth_____
Last First Middle

Address_____ Apartment #_____ ☐ Male ☐ Female

City_____ State_____ Zip_____

Social Security #_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Telephone (____)_____ (____)_____ (____)_____
Home Work Cell

E-mail_____ Ethnic group: ☐ Hispanic ☐ Non-Hispanic ☐ Decline info

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ African American ☐ Multiracial/Multicultural ☐ White ☐ Decline info

Primary Language: ☐ English ☐ Spanish ☐ Other _____

Employed by_____ City_____ State_____ Zip_____

RESPONSIBLE PARTY

Name_____ Date of Birth_____
Last First Middle

Address_____ Apartment #_____ ☐ Male ☐ Female

City_____ State_____ Zip_____

Social Security #_____ Relationship to patient_____

Telephone (____)_____ (____)_____ (____)_____
Home Work Cell

E-mail_____ Ethnic group: ☐ Hispanic ☐ Non-Hispanic ☐ Decline info

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ African American ☐ Multiracial/Multicultural ☐ White ☐ Decline info

Primary Language: ☐ English ☐ Spanish ☐ Other _____

Employed by_____ City_____ State_____ Zip_____

Please provide a copy of each side of all insurance cards with this form. If we do not receive these, we will assume the account is Self-Pay. Thank you!

Primary Medical Insurance_____

Subscriber (Person who carries this insurance) Name_____
Last First Middle

Date of Birth_____ Social Security #_____ Relationship to patient_____

Secondary Medical Insurance_____

Subscriber (Person who carries this insurance) Name_____
Last First Middle

Date of Birth_____ Social Security #_____ Relationship to patient_____

Emergency Contact Information

Nearest Friend/Relative not residing with you: **Telephone** (___)_____ (___)_____
Home Work

Name_____Relationship_____
Last First

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION/ASSIGNMENT OF BENEFITS OF ALL ENROLLEES

I authorize the Center for Family Medicine of Fairview Hospital to release the necessary medical information in connection with treatment to a referring physician, or rendered for the related claim to an insurance organization, or their representatives, including Medicare, Medicaid and utilization review organizations, by facsimile or mail, and assign the Center for Family Medicine of Fairview Hospital all benefits due me from any insurance organization, Medicare or Medicaid in payment on my behalf.

_____ _____
Signature (Parent or Guardian, if Minor) Date

CONSENT FOR TREATMENT OF ALL ENROLLEES

I hereby authorize my attending physician, and/or such practitioners and assistants as may be selected by him/her, to diagnose and treat the condition or conditions from which I am suffering by such means, including diagnostic, operation and/or surgical procedures, as he believes indicated by his studies of my case. I also authorize the above diagnosis/treatment for all minor children being enrolled at the Center for Family Medicine.

I consent to the photographing or televising that may be performed for medical, scientific or educational purposes, providing my identity is not revealed by the picture or by descriptive texts accompanying them.

The Center for Family Medicine is a teaching practice. Supervising physicians may observe office visits and procedures (either in person or remotely) during the course of insuring quality of care and resident education. I hereby consent to such observation of my care by supervising physicians at the Center for Family Medicine.

I retain the right to request cessation of recording or filming at anytime as well as the right to rescind consent before the recording, film, or image is used or released.

I am aware the practice of medicine and surgery is not an exact science, that complications may occur, and that no guarantees have been made to me concerning the results of my medical treatment.

This form has been fully explained to me and I certify that I understand the contents.

_____ _____
Signature (Parent or Guardian, if Minor) Date

Please provide a copy of each side of all insurance cards with this form. If we do not receive these, we will assume the account is Self-Pay. Thank you!

FOR OFFICE USE

Ins Card _____ Date _____ Initials _____ Received by_____ Date_____

Milcom _____ Date _____ Initials _____ Accepted by_____ Date_____

HIPPA _____ Date _____ Initials _____ Assigned Doctor:_____

CENTER FOR FAMILY MEDICINE
REGISTRATION and HISTORY QUESTIONNAIRE

NAME:_____ ☐ female ☐ male **Birth date:**___/___/___ **Marital status:** _____

Social Security Number: _____

Address: _____

_____

Your home phone #:_____

Your work phone #:_____

Who was your previous personal/family doctor?: _____

Person to contact in an emergency:_____

Relationship to you:_____

Their home phone #:_____

Their work phone #:_____

Location: _____

☞ **NOTE:** This is a confidential record of your medical history. As your family doctors, it is important for us to know this information so we can provide you with the best health care we can. The information contained here will not be releasesd to anyone without your prior consent.

PERSONAL HISTORY: Check any of the following that apply to you:

Illnesses/medical problems you have had:

☐ Anemia
☐ Arthritis
☐ Asthma
☐ Diabetes
☐ Eczema, hives
☐ Epilepsy
☐ Eye problems
☐ Heart disease
☐ Cancer; Type: _____
☐ Kidney/bladder problems
☐ Liver disease, hepatitis, jaundice
☐ Lung disease, tuberculosis
☐ Mental illness/depression
☐ Phlebitis/blood clots
☐ Substance abuse/alcoholism
☐ Stroke
☐ Ulcer in stomach/duodenum
☐ Uncontrolled bleeding
☐ Venereal disease (which? _____ _____)
☐ High blood pressure
☐ High cholesterol
☐ Thyroid disease

Other illnesses:

☐ _____
☐ _____
☐ _____

Surgery you have had: Year

☐ _____
☐ _____
☐ _____
☐ _____

Major hospitalizations:
(other than surgery) Year

☐ _____
☐ _____
☐ _____
☐ _____

Medicines you are taking:

☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

Allergies you have:

☐ _____
☐ _____
☐ _____

Education:

_____ Years of high school completed
_____ Years of college completed
_____ Years of post graduate school

Occupation: ☐ Student ☐ Retired

List your current & previous 1 - 2 jobs:

_____
_____
_____

Immunizations (check those you have had; note the most recent year received):

☐ Rubella 19____ ☐ Tetanus 19____
☐ Hepatitis 19____ ☐ Polio 19____
☐ Pneumonia 19____ ☐ Flu 19____
☐ Other: _____ 19____
_____ 19____

Other information:

☐ Received a blood or plasma transfusion
Do you wear seat belts? ☐ Yes ☐ No
Do you smoke:
☐ cigarettes (___packs/day, since 19___)
☐ used to smoke but quit in 19____
☐ alcohol (how much per week?_____)

FAMILY HISTORY

Check in the boxes below if any blood relatives have had any of the following illnesses/medical problems **and list their relationship to you.**

☐ Anemia _____
☐ Arthritis _____
☐ Asthma _____
☐ Cancer _____
☐ Depression/suicide _____
☐ Diabetes _____
☐ Epilepsy _____
☐ Heart disease _____
☐ High blood pressure _____
☐ Mental illness _____
☐ Stroke _____
☐ Substance abuse/alcoholism _____
☐ Thyroid disease _____
☐ Tuberculosis/lung disease _____
☐ Uncontrolled bleeding _____

Number of brothers: _____
Number of sisters: _____
Number of sons: _____
Number of daughters: _____

If any of the following relatives have died, write in the approximate age and cause of death:

Father	____	_____
Mother	____	_____
Brothers	____	_____
Sisters	____	_____
Sons	____	_____
Daughters	____	_____
Other	____	_____

Reviewed by:

Doctor's initials: _____

Date: _____

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Cleveland, OH 44111
216-476-7088; 216-476-7323 (fax)

Fairview Hospital
a Cleveland Clinic hospital

FVF7013

I, _____, hereby authorize my attending physician and/or such physicians, assistants,
PATIENT, PLEASE PRINT
residents and students as may be selected by him/her, to diagnose and treat the condition or conditions from which I am suffering by such means including diagnostic, operations and/or surgical procedures, as he/she believes indicated by his/her studies of my case.

CONSENT TO CARE: I am presenting myself for diagnosis and treatment, and I voluntarily consent to the providing of such care including diagnostic procedures and medical treatment by employees and agents of this facility and by its Medical Staff as may in their judgment be necessary or advisable to treat my condition. 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 the results of treatments or examinations in the facility.

NOTICE: MEDICAL STAFF RELATIONSHIP: Physicians who render professional services to you at this facility may be independent practitioners and, therefore, not employees or agents of the hospital. The facility is not responsible for the acts or omissions of physicians that are not directed or controlled by the facility.

PRIVACY NOTICE AND USE OF PROTECTED HEALTH INFORMATION (PHI):
I acknowledge that I have received the Notice of Privacy Practices of the Cleveland Clinic Health System (CCHS). I understand that the Notice of Privacy Practices explains how CCHS may use and disclose confidential health information that identifies me. I consent to let CCHS use and disclose health information about me as described in the Notice of Privacy Practices. This includes information about substance abuse, mental health services and HIV if applicable. I consent to the release of health information to my insurer, other third party payors, and any agents or consultants that assist in my treatment, help CCHS get paid or carry out its health care operations.

You have the right to read our Notice before signing this Consent. The terms of the Notice may change from time to time. If we change our Notice, you may obtain a revised copy from any of our facilities.

GUARANTEE OF ACCOUNT:
In consideration of facility services to be rendered, I guarantee payment to this facility for all charges incurred on behalf of the above named patient, including any portion not paid by any insurance organization, Medicare or Medicaid. **Many insurance carriers require patients to call and receive prior authorization/notification for an admission or a procedure to be covered.** Failure to comply may result in the patient or guarantor being responsible for payment.

ASSIGNMENT OF INSURANCE BENEFITS:
In consideration of facility services to be rendered, I assign, transfer and convey all of the rights, titles and interest due me from any insurance organization, Medicare or Medicaid in payment on my behalf to this facility.

I authorize the Social Security Administration to release to this facility information regarding my Medicare entitlement.

This authorization will remain in effect for all inpatient and outpatient care provided by this facility until expressly revoked in writing by me. In the case of clinic patients, this authorization will remain in effect for one year from the date of this signature.

I acknowledge that the treatment for which I give this consent has been fully explained to me and I have read and fully understand this authorization as it applies to me.

My signature acknowledges that I have received the IMPORTANT MESSAGE FROM MEDICARE as applicable. I have reviewed the above information and acknowledge that it is correct.

DEPOSIT OF VALUABLES / LIMITATIONS OF LIABILITY:
This facility strongly recommends that you do not bring valuables (jewelry, credit cards, money, documents, etc.) with you to the hospital. Please leave such items at home or with your family. **THE FACILITY SHALL NOT BE RESPONSIBLE FOR PATIENTS' VALUABLES UNLESS THE VALUABLES ARE DEPOSITED AT ADMISSION IN THE ADMITTING DEPARTMENT SAFE.** If you do not deposit your valuables at admission, the facility's **LIABILITY IS LIMITED** to loss or damage caused by willful or wanton negligence. If you keep your valuables with you while you are in the facility, **YOU DO SO AT YOUR OWN RISK,** even if given to personnel after admission. Items that remain in the facility Lost and Found are kept for 60 days and then given to charity.

Date_____Time_____

_____
(Patient, Guardian, Administrator, Next of Kin)
(Circle One)

Witness _____

_____
Insured Certificate Holder
(If Different from Above)

Date/Time

GENERAL CONSENT FOR HEALTHCARE SERVICES

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Fairview Hospital
Lakewood Hospital
Lutheran Hospital
Cleveland Clinic hospitals

- ❑ Fairview Hospital
  18101 Lorain Avenue, Cleveland, Ohio 44111
- ❑ Lakewood Hospital
  14519 Detroit Avenue, Cleveland, Ohio 44107
- ❑ Lutheran Hospital
  1730 West 25th Street, Cleveland, Ohio 44113

I give permission to _____ Hospital to

☐ **Release To** ☐ **Receive From**

Name of person/Doctor/Hospital/Facility:_____

Street:_____ City:_____ State:_____ Zip: _____

Phone: H ( )_____ W ( )_____ Fax: ( ) _____

***Reason for Disclosure: (Must be completed prior to processing)**

☐ Continuity of Care/Follow Up ☐ Personal Use ☐ Legal ☐ Insurance

☐ Other (specify):_____

***INFORMATION TO BE RELEASED: (Must be completed prior to processing)**

☐ Entire Record	☐ Pertinent Summary Information	☐ History & Physical	☐ EKG
☐ ED Record	☐ Discharge Summary	☐ Operative Report	☐ Pathology Report
☐ Lab Results	☐ Radiology Reports	☐ Physical/Occupational Therapy Reports	☐ Consult Reports

☐ Other (specify):_____

***Dates of Treatment:_____

Patient Name:_____ Date of Birth:_____ SSN:_____ MRN:_____

Street:_____ City:_____ State:_____ Zip:_____

Phone: H ( )_____ W ( )_____ Fax: ( ) _____

I hereby authorize Cleveland Clinic Health System Hospital(s) to release or receive the health care information indicated above that is contained in my patient record. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis. This authorization may be revoked at any time by putting the revocation in writing and presenting it to Health Information Services. Any revocation will not apply to information that has already been released in response to this authorization. This authorization and consent will expire one year from the date of authorization written below. Any further disclosure requires the specific written consent of the person to whom it pertains or his/her legal representative; reliance on Cleveland Clinic Health System Hospital(s') authorization for release of relevant information is not sufficient for purposes of redisclosure.

***This authorization for release of information is not valid, according to privacy rule, if the asterisked areas on this authorization form have not been completed.

_____	_____	_____
***Signature of Patient / Legal Guardian / Administrator Executor or Next of Kin (Circle one)	Printed Name	***Date Signed
_____	_____	Identification Verified: ☐ Yes ☐ No
If patient unable to sign state reason why	Witness	

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION