KOHL'S Wellness Center

Ascension

Patient Registration

Date:_____ **Primary Care Physician and Phone Number:**_____

Patient Information				
Last Name	**First Name**	**Middle**	**Previous Name**	**Date of Birth**
Address		**City**	**State**	**Zip**
Patient's Sex __Male __Female	**Marital Status (optional)** __Single __Married __Divorced	**Social Security Number** __ __ __ - __ __ - __ __ __ __	**Home Phone** ( )	**Cell Phone** ( )
Email:		**Employer**	**City**	**Work Phone** ( )

Contact Person				
Last Name	**First Name**	**Home Phone** ( )	**Alternate Phone** ( )	**Relationship**

Insurance Information			
Primary Insurance – Insurance Name	**Phone Number** ( )	**Policy Number**	**Group Number**

Release of Information

I understand that I may review and receive a copy of my medical record during regular KWC business hours and it is my personal responsibility to pay any associated fees if required. I also understand that I may authorize other persons to receive a copy of my medical record by signing an authorization form identifying the persons, the purpose of the disclosure, type of information to be disclosed and the time period during which the disclosure to the person is permitted. KWC, staffed and managed by Ascension Wisconsin is hereby authorized to disclose any and all of the medical records of the patient to any third party provided access by law, such as but not limited to workers compensation carriers. The patient further authorizes the duly operating committees of the medical staff and hospital to review his/her medical record.

Acknowledgment of Receipt of Privacy Notice/Patient Rights and Responsibilities

___ I acknowledge that I have been offered a copy of Ascension Wisconsin's Notice of Privacy.
___ I acknowledge that I have been offered the Patient Rights and Responsibilities brochure.
___ I understand that the Notice of Privacy provides an explanation of the ways in which my health information may be used or disclosed by Ascension Wisconsin and of my rights with respect to my health information.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTOOD ALL CONSENTS, RELEASES and ACKNOWLEDGMENTS CONTAINED WITHIN THIS DOCUMENT AND IS COMPETENT TO EXECUTE.

Patient Signature

_____ Date:_____

Witness Signature (staff signature if patient is unable or unwilling to sign)

_____ Date:_____

For Office Use Only

Date Privacy Notice given to patient_____ Staff initials_____

___ Patient was unable or unwilling to complete this form or portions of this form.
Explain: