



**TRAINING:**  
**EMERGENCY**  
**ROOM**

**FULL REGISTRATION**



**FACESHEET**

VF2024



# Tracker / Worklist Tab

## Registration Worklist:

- All patients who are ready to be updated will be listed on the tab MHRH ED Registration.

| Arrival Time     | MRN     | FIN       | Bed     | Info | A          | Name             | Sex/GI | Arrival Mode | Consent Status    | Reason for Visit      | LOS  | Disposition | Reg Events | Reg | DR | RN | Events | PCP                | Comment | REG Comment |
|------------------|---------|-----------|---------|------|------------|------------------|--------|--------------|-------------------|-----------------------|------|-------------|------------|-----|----|----|--------|--------------------|---------|-------------|
| 10/12/2024 13:35 | 1234567 | 100545545 | PEDSS.D |      | 3 - Urgent | Test, Michael    |        | Walk In      | Consent Requested | 1 Knee pain-swelling  | 1.53 |             |            |     |    |    |        | Mazumdar MD, S     |         |             |
| 10/12/2024 13:55 | 4567854 | 100580545 | ED22.D  |      | 3 - Urgent | Jackson, Michael |        | Auto         | Consent Signed    | 1 Facial pain         | 1.34 |             |            |     |    |    |        | Savath MD, Vinc 22 |         |             |
| 10/12/2024 14:00 | 5765464 | 100254845 | ED09.D  |      | 3 - Urgent | Smith, Jane      |        | Ambulance    | Consent Requested | 1 Back pain           | 1.28 |             |            |     |    |    |        | Anwar MD, Asgh     |         |             |
| 10/12/2024 14:22 | 5465465 | 100855451 | ED04.D  |      | 3 - Urgent | Jones, Wanda     |        | Auto         | Consent Signed    | 1 Headache            | 1.06 |             |            |     |    |    |        |                    |         |             |
| 10/12/2024 14:37 | 8784656 | 100457411 | ED14.D  |      | 3 - Urgent | Danbury, William |        | Ambulance    | Consent Requested | 1 Substance Abuse     | 0.51 |             |            |     |    |    |        |                    |         |             |
| 10/12/2024 14:45 | 15456   | 100154854 | ED23.D  |      | 3 - Urgent | Williams, Robert |        | Ambulance    | Consent Requested | 1 Wrist pain-swelling | 0.43 |             |            |     |    |    |        |                    |         |             |

## Patient's Location:

- The patient's location is listed next to the patient's name

## Length of Stay:

- The patients are sorted by length of stay

| Arrival Time     | MRN     | FIN       | Bed     | Info | A          | Name             | Sex/GI | Arrival Mode | Consent Status    | Reason for Visit      | LOS  | Disposition | Reg Events | Reg | DR | RN | Events | PCP                | Comment | REG Comment |
|------------------|---------|-----------|---------|------|------------|------------------|--------|--------------|-------------------|-----------------------|------|-------------|------------|-----|----|----|--------|--------------------|---------|-------------|
| 10/12/2024 13:35 | 1234567 | 100545545 | PEDSS.D |      | 3 - Urgent | Test, Michael    |        | Walk In      | Consent Requested | 1 Knee pain-swelling  | 1.53 |             |            |     |    |    |        | Mazumdar MD, S     |         |             |
| 10/12/2024 13:55 | 4567854 | 100580545 | ED22.D  |      | 3 - Urgent | Jackson, Michael |        | Auto         | Consent Signed    | 1 Facial pain         | 1.34 |             |            |     |    |    |        | Savath MD, Vinc 22 |         |             |
| 10/12/2024 14:00 | 5765464 | 100254845 | ED09.D  |      | 3 - Urgent | Smith, Jane      |        | Ambulance    | Consent Requested | 1 Back pain           | 1.28 |             |            |     |    |    |        | Anwar MD, Asgh     |         |             |
| 10/12/2024 14:22 | 5465465 | 100855451 | ED04.D  |      | 3 - Urgent | Jones, Wanda     |        | Auto         | Consent Signed    | 1 Headache            | 1.06 |             |            |     |    |    |        |                    |         |             |
| 10/12/2024 14:37 | 8784656 | 100457411 | ED14.D  |      | 3 - Urgent | Danbury, William |        | Ambulance    | Consent Requested | 1 Substance Abuse     | 0.51 |             |            |     |    |    |        |                    |         |             |
| 10/12/2024 14:45 | 15456   | 100154854 | ED23.D  |      | 3 - Urgent | Williams, Robert |        | Ambulance    | Consent Requested | 1 Wrist pain-swelling | 0.43 |             |            |     |    |    |        |                    |         |             |

## Updating Registration:

- Highlight the patient you are going to update.
- Click on the ED Full Registration (Yellow Key)

# Patient Information Tab

Always Confirm all information with the patient.  
When entering a room.

ED Modify Registration

Images: Last Name: ZZTEST, First Name: MICHAEL, Middle Name: Person Alias: Preferred First Name: Previous First Name: Previous Last Name: Suffix: Date of Birth: 10/22/1994, Age: 30Y, Legal Sex: Male, \*Sex Assigned at Birth: Male, Preferred Pronoun: He/Him, Gender Identity: Male, \*Social Security Number: 789-25-6786, Reason for No SSN: Medical Record Number: 3506055, Financial Number: 1042219723, Trauma/Stroke/Downtime:

Patient Information Encounter Information Guarantor Information Insurance Primary Insurance Secondary Insurance Tertiary Insurance Quaternary MSP Insurance Summary Additional Contacts

Address Information: Homeless: Pt Phys Addr - Clear (c): Pt Alt Address - Clear (c): \*Pt Home (Mailing) Address: 241 NORTH RD, POUGHKEEPSIE, NY 12601-1154, Pt Physical Address: Add Address..., Pt Alternate Address: Add Address..., \*Country Code: Wschester County Code: 5551

Parent's Names: Driver's License Number: Parent 1 Name: Parent 2 Name: Alias: Alias Name Printed: Alias Name Non Printed: \*Citizen: US Citizen, Birthplace: \*Veteran Status: Military Veteran Status, Telephone #: \*Preferred Phone: Mobile Phone Number: Home Phone Number: ( ) -, \*Mobile Phone Number: ( ) -, Work Phone Number: ( ) -, Work Extension: Alternate Phone Number: ( ) -, \*HIE Consent: HIE Consent

Health Life Portal: \*Email Address: Reason for No Email: \*Access Offered: Email Address for portal Access

Personal Data: Change Demographics: \*Race(s): Race: Asian, Black or African American, Native Hawaiian or Pacific Islander, Other Race, Patient Chooses not to disclose, Unknown, White, \*Ethnic Group(s): Ethnic Group(s): Hispanic or Latino, Non-Hispanic, Patient Chooses not to Disclose, Unknown, \*Relationship Status: Relationship Status, \*Preferred Language: English, \*Religion: Religion Preference, Do we have permission to share y: VIP Indicator: Ambulatory Condition: Organ Donor: \*NPP: Notice Of Privacy Consent, Disease Alert: Person Comments: Person Comment: Previous Person Comments: \*TEST PT: Yes

Complete Cancel

FERMNV1 | P1962 | 10/13/2024 | 13:44

# Encounter Tab

## Referral Source:

This is always "Self" unless the patient is transferred from another facility.

Do we have permission to share your room number with your religious community.

## Accident/Work Comp/Motor vehicle Accident :

This is always "Self" unless the patient is transferred from another facility. If you select Yes, more fields will appear

Patient Information | **Encounter Information** | Guarantor Information | Insurance Primary | Insurance Secondary | Insurance Tertiary | Insurance Quaternary | MSP | Insurance Summary | Additional Contacts

Location  
Building: MH Main Building | Nurse/Ambulatory: MH Emergency Department | Room: Decon1 | Bed: D | Patient Type: Emergency | Medical Service: MER - MH Emergency Room Mail | Accommodations: | Isolation: |

Current Encounter Information  
\*Admit Type: Emergency | \*Referral Source: | \*Do we have permission to share...: | \*Reason for Visit: testing | \*Arrival Mode: Walk In | EMS Agency: | Other Amb Co: | \*Accident/Work Comp/Motor Ve...: |

Physicians  
\*Attending/Referring Physician: | \*Primary Care Physician: Clare MD, Kimberly | Reason for No PCP: | \*Referring Physician: | Reason for No Referring Phys: |

Additional Information  
\*Display in Directory?: Yes |

Account Data  
\*Registration Date: 10/20/2024 | \*Registration Time: 10:22 | Registration User ID: FERMINV1 | Full Reg User ID: | Arrive Date: 10/20/2024 | Arrive Time: 10:22 |

Encounter/Insurance Comment  
Encounter/Insurance Comment: |

Previous Encounter Comments  
|

ED Modify Comments  
|

Previous Quick/Modify/Consent Comments  
10/20/2024 10:24:57 ED Quick Reg Comment by: Fermin, Victor O  
Photo ID scanned, All information verified with Patient SSI Verified with Patient |

Miscellaneous Attending Physician Info  
|

Complete Cancel

Enter all your notes on the encounter here. Normally done at the end of the registration.

Fill in all required fields highlighted in yellow.

Notes from the Quick Reg Registrar

Location  
Building: MH Main Building | Nurse/Ambulatory: MH Emergency Department | Room: ED04 | Bed: D | Patient Type: Emergency | Medical Service: MER - MH Emergency Room Mail | Accommodations: | Isolation: |

Current Encounter Information  
\*Admit Type: Emergency | \*Referral Source: Self (Non-HC Facility Source of ... | \*Do we have permission to share...: No | \*Reason for Visit: pain | \*Arrival Mode: Ambulance | EMS Agency: Empress | Other Amb Co: | \*Accident/Work Comp/Motor Ve...: Yes |

\*Accident Date: | \*Accident Time: | \*Accident Description: | \*Accident Location: | \*Accident Occur at Hospital?: | \*Accident Type: | \*Accident State: |

If answered yes to work related injury or Motor Vehicle accident, you must fill in all required fields highlighted in yellow.

# Guarantor Tab

**Guarantor Information:**  
Patient 18 and older is always self.

Patient Information | Encounter Information | **Guarantor Information** | Insurance Primary | Insurance Secondary | Insurance Tertiary | Insurance Quaternary | MSP | Insurance Summary | Additional Contacts

\*Patient's Relationship to Guarant...  
Self

Search for Guarantor

Last Name: ZZTEST First Name: MICHAEL Middle Name: Date of Birth: 10/22/1984 Legal Sex: Male Social Security Number: 789-25-6398

Mailing Address

GT Addr - Same as Pt (s): GT Alt Addr - Same as Pt (s) or Cl...

GT Mailing Address: 241 NORTH RD  
POUGHKEEPSIE, NY 12601-1154

GT Alternate Address: Add Address...

Home Phone Number: Mobile Phone Number: (347)323-2102 Pager Number: (347)323-2102 Work Phone Number: Work Extension: Alternate Phone Number: Email Address: mikesanshtpeprah@hotmail.com

Complete Cancel

When the patient is over 18 years old, there is nothing to fill out. You must select "Self"

**Guarantor Information:**  
Patient 18 and older is always self.

## Search Relationship To Guarantor:

If the patient is 17 and younger, a guarantor must be listed. Search the Guarantor, to see if the Guarantor has an account in our system. If not, fill in the blanks.

Patient Information | Encounter Information | **Guarantor Information** | Insurance Primary | Insurance Secondary | Insurance Tertiary | Insurance Quaternary | MSP | Insurance Summary | Additional Contacts

\*Patient's Relationship to Guarant...  
Child

Search for Guarantor

Last Name: First Name: Middle Name: Date of Birth: Legal Sex: Social Security Number:

Mailing Address

GT Addr - Same as Pt (s): GT Alt Addr - Same as Pt (s) or Cl...

\*GT Mailing Address: Add Address... GT Alternate Address: Add Address...

\*Home Phone Number: Mobile Phone Number: Pager Number: Work Phone Number: Work Extension: Alternate Phone Number: Email Address:

Complete Cancel

Patient 17 years of age and younger a parent or legal guardian must be entered.

# Insurance Tab

## Section 1

### Insurance Information:

Select the relationship of the primary policy holder. (Self, Mother, Father, Spouse, etc.)

If the patient is not the primary holder of the insurance, search for subscriber. Search using name and Date of Birth. If the subscriber is not in our system, you will then enter all highlighted areas required.

The system will allow up to 4 different insurance plans to be entered.

## Section 2

### Employment Status:

Select the patient's employment status. (Employed, Unemployed, Retired, etc.). When selecting employed, you must search employer and fill in all the highlighted areas.

## Section 3

### Health plan:

Here you will list the insurance the patient is covered under by clicking on "Search Health Plan"

When the popup screen is displayed Enter the insurance name and select the correct insurance plan.(See image below)

Search plan:

Select plan:

## Section 4

### Co Payment:

Here you enter copay information.

- Is there a copay due?
- Copay amount due
- Total Amount Collected

### Authorization Required:

This defaults to "Follow-Up" we should never have to change it.

ED Modify Registration

Images: Last Name: ZZZTEST, First Name: MICHAEL, Middle Name: [Empty]

Person Alias: [Empty], Preferred First Name: [Empty], Previous First Name: [Empty], Previous Last Name: [Empty]

Suffix: [Empty], Date of Birth: 10/22/1984, Age: 39Y, Legal Sex: Male

\*Sex Assigned at Birth: Male, Preferred Pronoun: He/Him, Gender Identity: Male, \*Social Security Number: 789-25-6398

Reason For No SSN: [Empty], Medical Record Number: 3580655, Financial Number: 1042560233, Trauma/Stroke/Downtime: [Empty]

Patient Information | Encounter Information | Guarantor Information | Insurance Primary | Insurance Secondary | Insurance Tertiary | Insurance Quaternary | MSP | Insurance Summary | Add

\*Patient's Relationship to Subscriber: Self

Search for Subscriber

Last Name: ZZZTEST, First Name: MICHAEL, Date of Birth: 10/22/1984, Legal Sex: Male

Social Security Number: 789-25-6398, Sub Address - Same as Pt (s): [Empty]

\*Mailing Address: 241 NORTH RD, Poughkeepsie, NY 12601-1154

Home Phone Number: [Empty], Mobile/Pager Number: (347)323-2102, Work Phone Number: [Empty], Work Extension: [Empty]

Alternate Phone Number: [Empty]

Subscriber Employer Info

\*Employment Status: Employed

Search for Employer

Employer Name: MidHudson Regional Hospital, Street Address: 241 North Road, Street Address2: [Empty], Zipcode: 12601-1154

City: Poughkeepsie, State: NY, \*Business Phone Number: (845)483-5000, Extension: [Empty]

\*Occupation: Nurse

Plan Information

Search for Health Plan

Health Plan Financial Class: Medicaid HMO, Health Plan Type: Commercial, Health Plan Name: FIDELIS MCD, Health Plan Code: L11

\*Street Address: PO BOX 806, Street Address 2: [Empty], Country: US, \*Zipcode: 14226-0806

\*City: AMHERST, \*State: NY, Phone Number: (888)343-3547, Extension: [Empty]

Contact: [Empty]

Patient details on file with Payer

\*Last Name: ZZZTEST, \*First Name: MICHAEL, Middle Name: [Empty], \*Subscriber Member Number: 12345678900

Group Number: [Empty], CIN Number: AB12345C, Begin Effective Date: 10/20/2024, Verify Status: Required

Verify Source: [Empty], Verify Date: [Empty], Verifying Personnel ID: [Empty]

Enter patient information and Subscriber/Member ID. Then change Verify Status to verified

Copay Collection

\*Is there a copay due?: [Empty]

Financial Responsibility

Copay Amount Due: [Empty], Deductible Amount: [Empty], Co-Insurance Percent: [Empty], Additional Fees/Other: [Empty]

Total Amount Collected: [Empty]

Admission Notification

Authorization Information

Authorization Required: Follow-up

Second Authorization

Third Authorization

Fourth Authorization

Complete Cancel

Ready FERMINV1 P1962 10/20/2024 10:31

# Insurance Summary Tab

**Results:**  
Get more details like copay and insurance type

ED Module Registration

Primary MVP - Active [Click here to view the results.](#)

Images

Last Name: ZZZTEST

First Name: MICHAEL

Middle Name:

Person Alias:

Preferred First Name:

Previous First Name:

Previous Last Name:

Suffix:

Date of Birth:

Age:

Legal Sex:

\*Sex Assigned at Birth: Male

Preferred Pronoun: He/Him

Gender Identity: Male

\*Social Security Number: 789-25-6398

Reason For No S...

Stroke/Downtime:

Checking Eligibility:  
Click the icon to run all insurance listed.

Patient Information

Encounter Information

Guarantor Information

Insurance Primary

Insurance Secondary

Insurance Tertiary

Insurance Quaternary

MSP

Insurance Summary

Additional Contacts

Coverage Summary:

| COB | Health Plan | Carrier | Member Nbr | Encntr Plan Beg. Dt | Encntr Plan End Dt | Plan Type  | Subscriber | Relation | Eligible | Eligibility Submit Date | Eligibility Cache Date | Eligibility Cache Expire Date |
|-----|-------------|---------|------------|---------------------|--------------------|------------|------------|----------|----------|-------------------------|------------------------|-------------------------------|
| 1   | MVP MCD     | MVP     | 8004845    | 10/21/2024          | 12/31/2100         | Commercial |            | Self     | Active   | 10/21/2024 10:45        | 10/21/2024 10:45       | 11/1/2024 0:59                |
| 1   | MVP MCD     | MVP     | 800484     | 10/21/2024          | 12/31/2100         | Commercial |            | Self     | Error    | 10/21/2024 10:46        |                        |                               |

Icon Response:  
green check or red X will appear next to the insurance.  
This is **not** an indicator on whether the insurance is active or not. Use the Eligible column to see accurate response.

Eligible:  
Check insurance response here.

Misc Plans Reviewed?:

Utilization Management Status:

Discharge Plan Status:

Financial Assistance

Self Pay Start Date:

Insurance Comments

Insurance Comments:

Complete

Cancel

Ready

FERMINV1 | P1962 | 10/20/2024 | 10:36

# Additional Contacts

ED Modify Registration

Primary MEDICARE - Error [Click here to view the results.](#)

**Patient's Relationship to Contact:**  
First select the relation to the patient.  
Contact is the Mother, Spouse, Child, Other, etc.

**Last and First name:**  
Enter the contacts first & last name.

**Address & Telephone:**  
Enter the contacts mailing address and telephone #.

Preferred First Name:

Previous First Name:

Previous Last Name:

Preferred Pronoun:

Gender Identity:

\*Social Security Number:

Patient Information | Encounter Information | Guarantor Information | Insurance Primary | Insurance Secondary | Insurance Tertiary | Insurance Quaternary | MSP | Insurance Summary | Additional Contacts

**Emergency Contact**

\*Patient's Relationship to EC:

Reason for No EMC:

\*Last Name:

\*First Name:

Date of Birth:

Legal Sex:

EMC Addr - Same (s) or Clear (c):

EMC Mailing Address:

\*Home Phone Number:

Mobile/Pager Number:

Work Phone Number:

Work Extension:

Alternate Phone Number:

Email Address:

\*Discharge Care Giver?:

**Next Of Kin**

Patient's Relationship to NOK:

Last Name:

First Name:

Date of Birth:

Legal Sex:

NOK Addr - Same (s) or Clear (c):

NOK Mailing Address:

Home Phone Number:

Mobile/Pager Number:

Work Phone Number:

Work Extension:

Alternate Phone Number:

Email Address:

\*Discharge Care Giver?:

**Additional Contact**

Patient's Relationship To AC:

Last Name:

First Name:

Date of Birth:

Legal Sex:

Contact Addr - Same (s) or Clear (c):

Reltn Mailing Address:

Home Phone Number:

Mobile/Pager Number:

Work Phone Number:

Work Extension:

Alternate Phone Number:

Email Address:

\*Discharge Care Giver?:

**Complete:**  
Once Completed, click "Complete"

Complete Cancel

Validation Error

FERMINV1 | P1962 | 10/20/2024 | 10:37

**Discharge Care Giver:**  
Enter whether this person will be a discharge care giver. The information entered here will be displayed in the Care giver Consent form at the end of this registration.

There can be up to 3 additional contacts listed.

- Emergency Contact
- Next Of Kin
- Additional Contact

Any missing consent forms will appear on this popup. All missing consent must be obtained. You can use the attached Wacom tablet or iPad to collect signatures

Sign eForms

Select a parent:

ZZZTEST, MICHAEL - Encounter

| Form Name                                 | Document Type      | Subject                                   | Reason Not Completed | Date Last Presented |
|-------------------------------------------|--------------------|-------------------------------------------|----------------------|---------------------|
| Care Act - MHRH                           | Consent Forms      | Care Act                                  |                      |                     |
| General Consent for Treatment - MHRH      | Consent Forms      | General Consent For Treatment             |                      | 10/21/2024 11:37:13 |
| HIXNY Electronic Data Access Consent Form | Person Level Forms | HIXNY Electronic Data Access Consent Form |                      | 02/13/2023 09:21:27 |
| No Surprise Act Disclosure Form - MHRH    | Consent Forms      | No Surprise Act Disclosure Form           |                      | 10/21/2024 11:37:14 |
| Notice of Privacy Practice - MHRH         | Consent Forms      | Notice of Privacy Practice                |                      | 10/21/2024 11:37:14 |
| Patient Registration Supplemental Form    | Person Level Forms | Patient Registration Supplemental Form    |                      | 03/02/2024 09:45:20 |

Present
Select Forms
Print
Refresh
Close

Name: ZZZTEST, MICHAEL  
DOB: 10/22/1984 Age: 39 years Gender: Male  
Ath. Physn: Papish MD, Mark A  
Admit Date: 10/21/2024 Fin. Class: Medicaid HMO  
FIN: 1042594562 MRN: 3580655

ACCESS TO PROTECTED HEALTH INFORMATION  
AUTHORIZATION

3211 (Rev. 03/23) Page 1 of 1

Name of Patient: ZZZTEST, MICHAEL

I hereby assign the person below as the Caregiver:

| Name     | Relationship to Patient | Address                             | Telephone      |
|----------|-------------------------|-------------------------------------|----------------|
| DOE JANE | SPOUSE                  | 241 NORTH RD POUGHKEEPSIE, NY 12601 | (845) 483-5000 |
|          |                         |                                     |                |
|          |                         |                                     |                |

I hereby decline assigning any Caregiver:

“CAREGIVER” shall mean any individual duly identified as a caregiver by a patient under this article who provides after-care assistance to a patient living in his or her residence. An identified caregiver shall include, but is not limited to, a relative, partner, friend or neighbor who has a significant relationship with the patient.

Patient Name (Print) ZZZTEST, MICHAEL Date/Time

Patient Signature: Date/Time

VF2024 OFFICE USE ONLY:

☐ Patient is unable to provide consent due to condition

☐ Patient refused to sign

Hospital Staff Person's Name Date & Time

**Discharge Care Giver Form:**  
All the information entered in the additional contact tab will appear here at the end.



**FULL  
REGISTRATION  
COMPLETED**