Rushville Family Practice
A Department of Culbertson Memorial Hospital

233 South Congress
Rushville, IL 62681
Phone: 217-322-3345
Fax: 217-322-6878
cmhospital.com/culbertsonclinics

Thank you for choosing Rushville Family Practice for your Healthcare needs. We always strive to provide quality, compassionate care to the communities we serve.

PLEASE ARRIVE TO THE CLINIC 30 MINUTES EARLY FOR YOUR APPOINTMENT

Please bring the following with you to your appointment:

- ☐ Driver's License or Photo Id
- ☐ All Current Insurance Cards
- ☐ All Current Medications In Their Original Bottles
- ☐ FOR MINORS: Consent to Treat
- ☐ New Patient Packet (Please complete and sign all forms before appointment)
  - Demographics
  - Clinical History
  - Patient Authorization to Permit Use and Disclosure of Health Information
  - No Show Policy

If you cannot make it to your scheduled appointment,

please call in advance to cancel or reschedule.

(217) 322-3345

Thank you!

Rushville Family Practice Providers and Staff

Alexis Murk, DNP-FNP

Kerstin Stitt, DO

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PATIENT DEMOGRAPHIC INFORMATION

PATIENT INFORMATION

LAST NAME:	FIRST:	M.I.:	GENDER:
PREFERRED NAME:	MAIDEN NAME:	DOB:	
SSN:	EMAIL:		
ADDRESS:			
CITY:	STATE:	ZIP:	COUNTY:
PRIMARY PHONE:	SECONDARY PHONE:		
RELIGION:	RACE:		

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ REFUSED TO ANSWER

PRIMARY LANGUAGE SPOKEN: **INTEPRETER NEEDED:** ☐ YES ☐ NO

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPERATED ☐ WIDOWED

TOBACCO USER: ☐ YES (EVERY DAY) ☐ YES (SOME DAYS) ☐ NEVER ☐ FORMER

IF YES, TYPE: ☐ SMOKELESS TOBACCO ☐ SMOKABLE TOBACCO

CONTACT/BILLING INFORMATION

SPOUSE: ☐ N/A	DOB:
EMERGENCY CONTACT:	DOB:
PHONE:	RELATIONSHIP TO PATIENT:
FATHER: IF PATIENT IS MINOR CHILD	PHONE:
MOTHER: IF PATIENT IS MINOR CHILD	PHONE:

PATIENT EMPLOYER: ☐ N/A

OCCUPATION:	STATUS: ☐ FULL TIME ☐ PART TIME ☐ RETIRED ☐ NOT EMPLOYED
PHONE:	ADDRESS:

DO YOU HAVE INSURANCE: ☐ YES (A COPY OF YOUR INSURANCE CARD IS REQUIRED) ☐ NO (PRIVATE PAY)

INSURANCE SUBSCRIBER: (THE PERSON WHO ENROLLED FOR THE INSURANCE) ☐ **CONTACT INFO SAME AS PATIENT**

LAST NAME:	FIRST NAME:		M.I.:
ADDRESS:			
CITY:	STATE:	ZIP:	COUNTY:
PRIMARY PHONE:	SECONDARY PHONE:		

RESPONSIBLE PARTY: (THE PERSON WHO IS RESPONSIBLE FOR THE BALANCE) ☐ **SAME AS INSURANCE SUBSCRIBER**

LAST NAME:	FIRST NAME:		M.I.:
ADDRESS:			
CITY:	STATE:	ZIP:	COUNTY:

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Name____

CLINICAL HISTORY

PRIMARY PHONE:	SECONDARY PHONE:

PREVENTIVE HEALTH

ADULTS When was your last vaccine for:		**PEDIATRIC**
TETANUS:	SHINGLES:	IMMUNIZATIONS UP TO DATE: ☐ YES ☐ NO
FLU:	PNEUMONIA:	WHERE RECEIVED:
HEPATITIS:	COLONSCOPY:	*PLEASE PROVIDE A COPY OF YOUR CHILD'S COMPLETE IMMUNIZATION RECORD*
MAMMOGRAM: (Female Only)	PAP SMEAR: (Female Only)	

MEDICAL HISTORY / FAMILY HISTORY

MEDICAL HISTORY		FAMILY HISTORY
ANXIETY/DEPRESSION	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
ANEMIA	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
ARTHRITIS	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
ASTHMA	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
CANCER	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
CATARACTS/GLAUCOMA	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
COPD	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
DIABETES	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
HEART DISEASE	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
HIGH BLOOD PRESSURE	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
HIGH CHOLESTEROL	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
KIDNEY DISEASE	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
STROKE	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
THYROID DISEASE	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
OTHER:		OTHER:

ALLERGIES ☐ No Known Allergies

NAME:	REACTION:
NAME:	REACTION:
NAME:	REACTION:
NAME:	REACTION:

SURGICAL HISTORY

SURGERY:	DATE:	SURGERY:	DATE:
SURGERY:	DATE:	SURGERY:	DATE:
SURGERY:	DATE:	SURGERY:	DATE:
SURGERY:	DATE:	SURGERY:	DATE:

RECENT HOSPITALIZATION/ER VISITS

REASON:	DATE:	REASON:	DATE:
REASON:	DATE:	REASON:	DATE:

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CLINICAL HISTORY

SOCIAL HISTORY

TOBACCO: ☐ NON-SMOKER ☐ FORMER SMOKER When Did You Quit: ________________

☐ CURRENT SMOKER
HOW MUCH: ____ PACK(S) PER DAY

WHAT TYPE: ☐ CIGARETTES ☐ SMOKELESS TOBACCO ☐ ELECTRONIC CIGARETTE

ALCOHOL: ☐ NON-DRINKER ☐ FORMER DRINKER When Did You Quit: ________________

☐ CURRENT DRINKER
HOW MUCH: ☐ 1-2 DRINKS DAILY ☐ 3-4 DRINKS DAILY ☐ MORE THAN 5 DRINKS DAILY ☐ ONCE A WEEK

☐ OCCASIONALLY ☐ SOCIALLY

WHAT TYPE: ☐ WINE ☐ BEER ☐ SPIRITS

CAFFEINE: ☐ NO

☐ YES
HOW MUCH: ☐ 1-2 CUPS DAILY ☐ 3-4 CUPS DAILY ☐ 1-2 CUPS WEEKLY ☐ 3-4 CUPS WEEKLY

☐ MORE THAN 5 DAILY ☐ MORE THAN 5 WEEKLY

PRESCRIPTION DRUG ABUSE: ☐ NO ☐ YES ________________________________

ILLICIT DRUG ABUSE: ☐ NO ☐ YES ________________________________

EXERCISE:
☐ NONE ☐ WALKING ☐ RUNNING ☐ WEIGHT LIFTING ☐ YOGA

☐ ZUMBA ☐ PILATES ☐ BIKING ☐ SWIMMING ☐ GARDENING

☐ OTHER: ____

CURRENT MEDICATIONS

PLEASE BRING ALL OF YOUR CURRENT MEDICATIONS IN THE BOTTLES TO YOUR APPOINTMENT

238 South Congress
Rushville, IL 62681
Phone: 217-322-4321
Fax: 217-322-2546
cmhospital.com

CULBERTSON OUTPATIENT SPECIALTY CLINICS PATIENT AUTHORIZATION

To Permit Use and Disclosure of Health Information

Re: ____ _____/_____/______
Patient Name/MR ID Number Date of Birth

I am either the patient named above or the patient's legally authorized representative. By signing this form, I authorize SARAH D. CULBERTSON MEMORIAL HOSPITAL AND its designees to disclose PHI to the following individuals:

Name of Individual	Relationship to Patient	Phone Number

(Person or class of persons to whom disclosure would be made)

The purpose of the use or disclosure is: At the request of the above-named individual.

I understand that I may revoke this Authorization at any time except to the extent that action has been taken in reliance on it. The procedure for revoking this authorization is to send a written request to: Sarah D. Culbertson Memorial Hospital, Attn: Privacy Officer, 238 South Congress Street, Rushville, IL 62681. The request must include my full legal name, date of birth, the effective date of the revocation, and the names to be revoked.

I understand I may refuse to sign this Authorization. I also understand Sarah D. Culbertson Memorial Hospital will not condition the patient's treatment or any payment, enrollment in a health plan, or eligibility for benefits on receiving my signature on this Authorization.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under federal medical privacy law.

This authorization expires automatically upon revocation by me or upon my death.

I have read and understand the information in this authorization form.

Signature of Patient:	
Please print name:	Date:

REVISED 01/15/2026 mls

Culbertson Clinics
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238 South Congress
Rushville, IL 62681
Phone: 217-323-2245
Fax: 217-323-9362
cmhospital.com

Patient Appointment Cancellation, No-Show, and Late Arrival Agreement

Our goal is to provide excellent care for each patient in a timely manner. Keeping scheduled appointments allows our Medical Providers to care for all patients efficiently and ensures appointment availability for those in need of medical services.

No-Show: A patient who fails to arrive for a scheduled appointment.

Same-Day Cancellation: A patient who cancels an appointment less than 24 hours before the scheduled appointment time.

Late Arrival: A patient who arrives 15 minutes or more after the scheduled appointment time.

Appointment Cancellation Policy

If it is necessary to cancel an appointment, patients are required to notify the registration department at least 24 hours prior to the scheduled appointment time. Timely notification allows the Schuyler County Hospital District and Schuyler County Hospital District Health Centers to offer the appointment to another patient who may need care.

Late Arrival Policy

Patients who arrive more than fifteen (15) minutes late may not be able to be seen by the provider on the same day. If the provider is unable to see the patient due to late arrival, the appointment may be rescheduled for a future date. In these cases, the late arrival will be documented as a no-show.

Monitoring No-Shows and Late Cancellations

The Schuyler County Hospital District and Schuyler County Hospital District Health Centers monitor and manage appointment no-shows and late cancellations in order to maintain access to care for all patients.

- Three (3) documented no-shows or same-day cancellations within a 12-month period will result in a written warning letter notifying the patient of possible revocation of scheduling privileges.
- Four (4) documented no-shows or same-day cancellations within a 12-month period will result in revocation of scheduling privileges. Patients will then only be eligible to receive care on a walk-in basis, subject to provider availability.

Patient Acknowledgement

By signing below, I acknowledge I have received, read, and understand the Schuyler County Hospital District and Schuyler County Hospital District Health Center's Appointment Cancellation, No-Show, and Late Arrival Policy. I understand that failure to comply with this policy may result in limitations on my ability to schedule future appointments.

Patient Name (Print): ______________________________

Patient or Patient Representative Signature: ______________________________

Date: ______________________________