Patient Registration Form

If you need any assistance completing paperwork, please speak to the front desk.

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City_____ State_____ Zip_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact: _____ Emergency Contact Number: _____

Emergency Contact Relationship to Patient: _____ Guarantor Name: _____

Primary Care Provider: _____ Phone #: _____

Patient Date of Birth: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Divorced ☐ Married ☐ Partner ☐ Single ☐ Widowed ☐ Separated

Patient Social Security Number: _____ Guarantor Social Security Number: _____

Patient Employer Name: _____

Patient Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Self Employed ☐ Retired ☐ Active Military

Student Status: ☐ Full Time ☐ Part Time ☐ Not a Student

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian ☐ Black or African American
☐ White Hispanic ☐ Other Race ☐ Other Islander ☐ Choose not to Disclose

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

What is your primary language? _____ Do you need an interpreter? ☐ Yes ☐ No

Pharmacy Name: _____ Pharmacy Address: _____

Are you an agricultural migrant worker: ☐ Yes ☐ No Are you a seasonal worker: ☐ Yes ☐ No

Are you a veteran: ☐ Yes ☐ No

Please mark the statement below which best describes your current living situation:

☐ I live in my own home which I rent, lease or own
☐ I am staying with a series of friends and/or extended family members on a temporary basis
☐ I am staying in supportive or transitional housing *(Such as a sober living facility or recovery home)*
☐ I live in a public or private facility that provides temporary shelters *(shelter, mission, single room occupancy facility, motel)*
☐ I have been released from an institution *(such as jail or hospital)* without stable housing to return to
☐ I live on the streets, in a car, park, sidewalk, in an abandoned building, or any unstable or non-permanent situation.
☐ I live in a foster care environment.

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male *(female to male)* ☐ Transgender Female *(male to female)*
☐ Other ☐ Choose not to disclose

If over the age of 18 please answer, what is your sexual Orientation:

☐ Lesbian or Gay ☐ Straight (not lesbian or gay) ☐ Bisexual ☐ Other ☐ Choose not to disclose

How did you hear about us? ☐ Radio ☐ Newspaper ☐ Facebook ☐ Friend or Relative
☐ Poster/Flyer Search Engine *(Google, Yahoo, etc.)* ☐ Achc-ks.org ☐ Referral from hospital
☐ Other:

What is your e-mail Address: _____

May we text you appointment reminders: ☐ Yes ☐ No If yes, in the ☐ morning or ☐ afternoon

Signature of Person Completing this Form: _____ Relationship to the Patient: _____

INSURANCE

Do you have Health Insurance? ◯ **Yes** ◯ **No**

If yes, please fill in the following information.

Primary Insurance Company: _____ ID #: _____

Primary Insurance Subscriber First and Last Name: _____

Subscriber Birth Date: _____ Subscriber Social Security #: _____

Do you have Secondary Health Insurance? ◯ **Yes** ◯ **No**

If yes, please fill in the following information.

Primary Insurance Company: _____ ID #: _____

Primary Insurance Subscriber First and Last Name: _____

Subscriber Birth Date: _____ Subscriber Social Security #: _____

Do you have Dental Insurance? ◯ **Yes** ◯ **No**

If yes, please fill in the following information.

Primary Insurance Company: _____ ID #: _____

Primary Insurance Subscriber First and Last Name: _____

Subscriber Birth Date: _____ Subscriber Social Security #: _____

Signature: _____ **Date:** _____

Printed Name: _____ **Date:** _____

Atchison Community Health Clinic

Consent

I hereby give consent for the clinic to leave telephone messages regarding my appointment dates and times.

I here by give consent for the clinic to send text message regarding my appointment dates and times.

I understand that the Atchison Community Health Clinic is not responsible for any bills incurred outside its services such as ambulance, emergency room visits, outpatient or inpatient hospital care, diagnostic tests (x-rays, lab, etc.), specialist referrals, ongoing medications or medical supplies

If I am unable to keep a referral appointment, I am required to cancel the appointment with the doctor's office or hospital prior to the appointment time.

All information provided within this packet is correct and current as of this date.

I herby give consent to the provider to view my prescription history from other services.

I herby authorize the provider to furnish my insurance company all information which the insurance company requests concerning my present illness/injury. I, hereby assign to the provider all money to which I am entitled for medical and/or surgery expense relative to the services, but not to execute indebtedness to the provider/surgeon. It is understood that any money received from my insurance company over and above my any money owed to ACHC is to be refunded to me when my bill is paid in full. I understand I am responsible to the provider(s) for charges not covered by this assignment. Charges shown by statements are assumed to be correct and reasonable unless protested in writing within thirty (30) days of billing date. In the event action should become necessary to collect unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fee or other such costs as the court determines proper. It is agreed that payment will not be delayed or withheld because of insurance coverage of the pendecy of claims thereon. All proceeds of insurance are assigned to this office where applicable. We are an equal opporunity provider.

Print Name: _____ **DOB**:_____

Signature: _____ **Date**:_____

Please remember to bring your medications and your insurance card to each visit. If you have applied for the sliding fee discount and have a change in house hold income please bring updated proof of income to your appointment.

Consent for Treatment and Policies of the Atchison Community Health Clinic

I give permission for evaluation and treatment for myself, or a minor child, by personnel employed by the Atchison Community Health Clinic, or volunteers of the clinic.

I understand that I have the right to refuse any specific diagnosis or treatment service without jeopardizing my right to receive health services at the Clinic, but I also understand that certain medications will not be prescribed because of this refusal. I understand that health services are not based on an exact science, and I acknowledge that no guarantees have been made to me as to the results of any treatment services.

I understand that the Atchison Community Health Clinic does not provide emergency care or chronic pain management.

I understand that if I am unable to keep my appointment, I must give the clinic 24 hours advance notice or I will be marked as a no show. I understand after two consecutive no shows or three no shows in 90 days, I will be required to speak to the case manager before scheduling a new appointment.

I understand that all files are kept confidential in their use by the Atchison Community Health Clinic staff and that my written consent is required for any release of information by the Atchison Community Health Clinic to other persons or agencies, except as required by law in cases of court orders, child abuse, life threatening situations, national security issues, and to the Atchison Hospital for the purpose of uncompensated care. In court ordered evaluations, any and all relevant information, including previously obtained material, may be realeased to the court.. The staff is required by law to report any suspicion of child, elder or vulnerable person abuse, including neglect, emotional, physical or sexual abuse.

My financial or statistical information may be released to funding sources which directly benefit me or assist the Atchison Community Health Clinic in providing services..

In an apparent life-threatening situation, I, or my minor child above will be take to a hospital emergency room by ambulance. Payment for ambulance services, emergency services and emergency room care will be my responsibility.

I acknowledge that some medication provided by the Clinic may not be in childproof containers. As such, I accept the responsibility for maintaining this medication in a safe and secure location.

I may be referred to a specialist for consultation. The clinic is not responsible for charges incurred from specialist. A referral is for one office visit only. Payment for test or procedures ordered by a specialist is my responsibility, therefore, I will discuss such payment with the specialist in advance. I understand I should not expect the specialist to provide ongoing help unless I am willing to pay for it.

For any lab or sample sent to an outside lab, there will be an additional charge.

I have read the "Consent for Treatment and Policies of the Atchison Community Health Clinic" stated above. I understand them or have had someone clarify to me anything I did not understand. I agree to the terms state in the above Consent and policies.

My signature on this form signifies that I have read and understand the above information.

Printed Name: _____ **DOB**:_____

Signature: _____ **Date**:_____

Acknowledgement of Receipt of Revised Notice of Privacy Practices

I acknowledge that I have received a copy of the Atchison Community health Clinic's Notice of Privacy Practices.

Signature: _____ **Date**:_____

Printed Name: _____

Relationship to patient: _____

Signature of Employee Witness:_____ **Date**:_____

Documentation of Good Faith Efforts

Patient Name: _____ **Date**:_____

The patient presented to the facility on this date and was provided with a copy of the Atchison Community Health Clinic's Notice of Privacy Practices. A good faith effort was made to obtain from the patient (or the patient's representative) a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

◯ **Patient/Patient Representative refused to sign.**

◯ **Patient/Patient Representative was unable to sign because:** _____

_____

_____

◯ **Patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.**

◯ **Other reason:** _____

_____

Signature of Employee Completing Form:_____

UDS Data

Are you interested in applying for the Sliding Fee Discount? ◯ YES ◯ NO

If **YES**, please complete the form below AND the Application for Discounted Services Form.
If **NO**, complete only the form below.

In order to comply with federal grant guidelines, we must ask you to circle one of the boxes listed below.

Locate the box with the number of people of in your household. Within that box, circle the total annual household income before taxes.

First Name: _____ Last Name: _____ Date of Birth: ____ / ____ / ____

1 Person in Household
Choose below where your total annual household income falls before taxes.
$0.00 - $12,140
$12,141 - $18,210
$18,211 - $24,280
$24,281 +

2 People in Household
Choose below where your total annual household income falls before taxes.
$0.00 - $16,460
$16,461 - $24,690
$24,691 - $32,920
$32,921 +

3 People in Household
Choose below where your total annual household income falls before taxes.
$0.00 - $20,780
$20,781 - $31,170
$31,171 - $41,560
$41,561 +

4 People in Household
Choose below where your total annual household income falls before taxes.
$0.00 - $25,100
$25,101 - $37,650
$37,651 -$50,020
$50,021 +

5 Person in Household
Choose below where your total annual household income falls before taxes.
$0.00 - $29,420
$29,421 - $44,130
$44,131 - $58,840
$58,841 +

6 People in Household
Choose below where your total annual household income falls before taxes.
$0.00 - $33,740
$33,741 - $50,610
$50.611- $67,480
$67,481 +

7 People in Household
Choose below where your total annual household income falls before taxes.
$0.00 - $38,060
$38,061 - $57,090
$57,091 - $76,120
$76,121 +

8 People in Household
Choose below where your total annual household income falls before taxes.
$0.00 - $42,380
$42,381 - $63,570
$63,571 - $84,760
$84,761 +

Revised: 09/01/2018

Application for Discounted Services

Proof of income is required prior to receiving discounted services. Include income for everyon in the household over the age of 18.

First Name: _____ Last Name: _____ Middle: Date of Birth: ____/____/____

How many people live in your household? _____

Do you split bills? (rent/utilities) YES NO

Do have proof of income with you today? YES NO

Do you have insurance? YES NO

Are you currently employed? YES NO

If employed, answer the below questions:

What is your hourly rate? _____

How many hours worked in a week? _____

Name of employer? _____

List All Member of Household	Relationship to the Patient					Currently Employed		If Empoloyed		
Last Name, First Name	spouse	child	parent	friend	other	YES	NO	Hours worked per week	Hourly rate of pay	Employer Name
Mouse, Mickey	*X*					*X*		*40*	*$12.00*	*Disney Company*
									$	
									$	
									$	
									$	
									$	
									$	

Do you or does anyone in the household receive any of the following? If yes, please fill in the total amount received before taxes or deductions.

Alimony	YES	NO	$ _____	Pension	YES	NO	$ _____
Cash Support from friends or family	YES	NO	$ _____	Social Security (SSI or SSD)	YES	NO	$ _____
Child Support	YES	NO	$ _____	SRS Income (Cash Assistance/,	YES	NO	$ _____
Food Stamps	YES	NO	$ _____	Unemployment	YES	NO	$ _____
Other	YES	NO	$ _____	Worker's Compensation	YES	NO	$ _____

By signing below, I state that the above financial information is correct. I agree to provide all financial information on a yearly basis in order to qualify for discounted services. I agree to notify Atchison Community Health Clinic immediately if my financial situation changes during the year. I understand that if Atchison Community Health Clinic finds that I have intentionally given false information, I will immediately forfeit my rights to discounted services.

Signature: _____ Date: _____

Office Use Only: Initials: _____ Family Size: _____ Total Yearly Income: $_____ POI: YES NO

Notes: _____

SLIDE A - $15.00 _____ SLIDE B - $30.00 _____ SLIDE C - $40.00 SLIDE D - FULL FEE