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: _____

Responsible Party Name: _____Responsible Party Phone #: _____

Responsible Party Social Security Number: _____Responsible Party Date of Birth: _____

Patient Date of Birth: _____ / _____ / _____ Sex at birth: □ Male □ Female

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

Patient 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

Emergency Contact: _____ Emergency Phone Number: _____

Emergency Contact Relationship to Patient: _____

Race: □ American Indian or Alaskan Native □ Asian □ Native Hawaiian □ Black or African American
□ White □ 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 agricultural* worker: □ Yes □ No

Are you a veteran: □ Yes □ No

Please mark the statement below which best describes your current living situation:
□ PERMANENT housing – I live in a home that I own, lease or pay rent.
□ TEMPORARY housing - My housing is unstable. I often stay with a series of friends or extended family and do not pay rent.
□ I am a college student and live in campus housing.
□ 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.

Gender Identity: □ Male □ Female □ Transgender Male (*female to male)* □ Transgender Female *(male to female)*
□ Other □ Don't' know □ 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

What is your e-mail Address: _____

Signature: _____Relationship to the Patient: _____Date: _____

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 #: _____

Subscriber Relationship to Patient: _____

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 #: _____

Subscriber Relationship to Patient: _____

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 #: _____

Subscriber Relationship to Patient: _____

Signature: _____

Printed Name: _____ **Date:** _____

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 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**:_____

This notice describes how medical information about you may be used and disclosed and how you can obtain access to your medical information. Please review it carefully.

You have the right to a paper copy of this notice; you may request a copy at any time. Atchison Community Health Clinic (ACHC) is required by law to maintain the privacy of protected health information, to provide individuals with notice of its legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information.

These entities, sites, and locations follow the terms of this notice, and in addition, may share medical information with each other for treatment, payment or ACHC operation purposes described in this notice. These sites and locations include the Atcison Community Health Clinic and Atchison Hospital.

How ACHC may use and disclose health information about you

ACHC may use and disclose your health information for the following purposes without your express consent or authorization.

Treatment: We may use your health information to provide you with medical/dental treatment. We may disclose information to doctors, dentists, nurses, technicians, medical students, or other personnel involved in your care. We also may disclose information to other persons or organizations involved in your treatment, such as other health care providers, family members, and friends. We may use and disclose health information to discuss with you treatment options or health-related benefits or services or to provide you with promotional gifts of nominal value. We may use and disclose your health information to remind you of upcoming appointments. Unless you direct us otherwise, we may leave messages on your telephone answering machine identifying ACHC and asking for you to return our call. We will not disclose any health information to any person other than you except to leave a message for you to return the call.

Payment: We may use and disclose your health imformation as necessary to collect payment for services we provide to you. We may provide information to other health care providers to assist them in obtaining payment for services they provide to you.

Health Care Operations: We may use and disclose health information for our internal operations. These uses and disclosures are necessary for our day-to-day operations and to make sure patients receive quality care. We may disclose health information about you to another health care provider or health plan with which you also have had a realtionship for purposes of that provider's or plan's internal operations.

Business Associates: ACHC provides some services through contracts or arrangements with business associates. We require our business associates to appropriately safeguard your information.

Creation of De-Identified Health Information: We may use your health information to create de-identified health information. This means that all data items that would help identify you are removed or modified.

Uses and Disclosures Required by Law: We will use and/or disclose your information when required by law to do so.

Disclosure for Public Health Activities: We may disclose your health information to a government agency authorized (a) to collect data for the purpose of preventing or control disease, injury, or disability; or (b) to receive reports of child abuse or neglect. We also may disclose such information to a person who may have been exposed to a communicable disease if permitted by law.

Disclosures about Victims of Abuse, Neglect, or Domestic Violence: We may disclose your health information to a government authority if we believe you are a victim of abuse, neglect, or domestic violence.

Disclosures for Judicial and Administrative Proceedings: We may disclose your health information in response to a court order or in response to a subpoena, discovery request, or other lawful process if certain legal requirements are satisfied.

Disclosures for Law Enforcement Purposes: We may disclose your health information to a law enforcment official as required by law or in compliance with a court order, court-ordered warrant, a subpoena, or summons issued by a judicial officer; a grand jury subpoena; or administrative request related to legitimate law enforcement inquiry.

Disclosures regarding Victims of a Crime: In response to a law enforcement official's request, we may disclose information about you with your approval. We may also disclose information in an emergency situation or if you are incapacitated if it appears you were the victim of a crime.

Disclosures to Avert a Serious Threat to Health or Safety: We may disclose information to prevent or lesson a serious threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

Disclosures for Specialized Government Functions: We may disclose your protected health information as required to comply with governmental requirements for national security reasons or for protection of certain government personnel or foreign dignitaries.

Disclosures for Fundraising: We may disclose demographic information and date of servie to affiliated foundations or a business associate that may contact you to raise funds for ACHC. You have a right to opt out of receiving such fundraising communications.

Other Uses and Disclosures: We will obtain your written authorization before using or disclosing your information for any other purpose not describe in this notice. For example, authorizations are required for use and disclosure of psychotherapy notes, certain types of marketing arrangements, and certain instances involving the sale of your information. You may revoke such authorization, in writing, at any time to the extent ACHC has not relied on it.

Your rights regarding your Health Information

Right to Inspect and Copy: You have the right to inspect and copy health information maintained by ACHC. To do so, you must complete a specific form providing information needed to process your request. If you request copies, we may charge a reasonable fee. We may deny you acess in certain limited circumstances. If we deny access, you may request review of that decision by a third party, and we will comply with the outcome of the review.

Right to request Amendment: If you believe your records contain inaccurate or incomplete information, you may ask us to amend the information. To request an amendment, you must complete a specific form providing information we need to process your request, including the reason that supports your request.

Right to an Accounting of Disclosures and Access Report: You have the right to request a list of disclosures of your health information we have made, with certain exceptions defined by law. To request an accounting or an access report, you must complete a specific written form providing information we need to process your request.

Right to Request Restrictions: You have the right to request a restriction on our uses and disclosures of health information for treatment, payment, or health care operations. You must complete a specific written form providing information we need to process your request. ACHC's privacy officer is the only person who has the authority to approve such a request. ACHC is not required to honor your request for restrictions, except if (a) the dislosure if for purposes of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or services for which you or any person (other than a health plan on your behalf) has paid ACHC in full.

Right to request Alternative Methods of Communication: You have the right to request that we communicate with you in a certain way or at a certain location. You must complete a specific form providing information needed to process your request. ACHC's Privacy Officer is the only person who has the authority to act on such a request. We will not ask you the reason for your request, and we will accommodate all reasonable requests.

Your Rights regarding Electronic Health Information Technology: The Atchison Community Health Clinic participates in electronic health information technology or HIT. This technology allows a provider or a health plan to make a single request through a health information organization or HIO to obtain elecronic records for a specific patient from other HIT participants for purposes of treatment, payment, or health care operations. HIOs are required to use appropriate safeguards to prevent unauthorized uses and disclosures.

You have two options with respect to HIT. First, you may permit authorized individuals to access your electronic health information through an HIO. If you chose this option, you do not have to do anything.

Second, you may restrict access to all of your information through an HIO (except as required by law). If you wish to restrict access, you must submit the required information either online at http://www.KanHIT.org or by completing and mailing a form. This form is available at http://www.KanHIT.org. You cannot restrict access to certain information only; your choise is to permit or restrict access to all of your information.

If you have questions regarding HIT or HIOs, please visit http://www.KanHIT.org for additional information.

If you receive health care services in a state other than Kansas, different rules may apply regarding restrictions on access to your electronic health information. Please communicate directly with your out-of-state health care provider regarding those rules.

Complaints

If you believe your rights with respect to health information have been violated, you may file a complaint with ACHC or with the Secretary of the Department of Health and Human Services. To file a complaint with ACHC, please contact Privacy Officer, 1412 North 2nd, P.O. Box 27, Atchison, Kansas 66002. All complaints must be submitted in writing. *You will not be penalized for filing a complaint.* ACHC reserves the right to change the terms of this notice and to make the revised notice effective with respect to all protected health information regardless of when the information was created.

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:_____

Self-Declaration of No Income

If you have no income please complete this form.

Last Name: _____First Name: _____ Middle Initial: ____
Date of Birth _____ Today's Date: _____
Date you last received income from working: _____

If you have received any of the following it MUST be listed on the Application for Discounted Services: Wages from employment (including commission, tips, bonuses, fees, etc.), Income for a business you own, Interest or dividends from assets, Social Security Payments (SSA, SSI) annuities, insurance policies, retirement funds, pensions or death benefits, unemployment or disability payments, worker's compensation, public assistance payments, child support, alimony or gifts received from persons not living in the household.

Please list below the cost of the following expenses and how you (or your family) have paid for your living expense.

Food: $_____

_____

_____

Utilities: $_____

_____

_____

Rent: $_____

_____

_____

I certify that the information in this Declaration is complete, true and accurate to the best of my knowledge. I understand that if I have knowingly given false information, any discounts applied to my account ***will be FORFEITED.***

Signature: _____ Date: _____

Employee Witness: _____ Date: _____