RIVERHILLS COMMUNITY HEALTH CENTER

Diversified Services · Exceptional Healthcare

Patient Registration Form

ATTENTION: Please provide copies of insurance cards at time of registration. If you do not have insurance or need assistance in paying for services, you will need to complete a Sliding Fee Application which is available at the front desk.

Patient Information

Last Name_____ **First Name**_____ **MI**____ **Soc. Sec. #** _____-____-_____

Address_____**Apt/Unit**_____**City**_____**State**_____

Zip_____**County**_____ **Date of Birth**_____ **Gender:** ☐ Male ☐ Female

Home Phone #_____ **Cell Phone #**_____ **Email**_____

May We Leave Messages regarding the following:

Appointments, pre-medication and instruction appointments? ☐Yes ☐No

Medical or Dental information? ☐Yes ☐No

Information about our Sliding Fee Discount Program? ☐Yes ☐No

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

Employment Status: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Retired ☐ Unemployed

Student Status: ☐ Full-time ☐ Part-time ☐ N/A **Military Status:** ☐ Active ☐ Retired ☐ Veteran ☐ N/A

Race (Please choose one): ☐White/Caucasian ☐Asian ☐Black/African American ☐American Indian/Alaskan Native ☐Other Pacific Islander ☐Native Hawaiian

Ethnicity (Please choose one): ☐Hispanic/Latino ☐Non-Hispanic or Latino

Primary Language: ☐English ☐Spanish ☐Other_____ **Are Interpretation Services Needed?** ☐Yes ☐No

Employer:_____ **Occupation:**_____

Do you currently receive public housing? ☐Yes ☐No

Emergency Contact_____ **Relationship**_____ **Phone #**_____

Responsible Party (parent/guardian/person who will pay the bill). If patient is responsible party, skip this section.

Last Name_____ **First Name**_____ **MI**____ **Soc. Sec. #** _____-____-_____

Address same as Patient ☐ **If Not: Address**_____ **City**_____ **State**_____ **Zip**_____

County_____ **Date of Birth**_____ **Gender:** ☐Male ☐Female **Phone #**_____

Insurance Policyholder: ☐Yes ☐No **Employer**_____

Patient's Relationship to Responsible Party:

☐Spouse ☐Child ☐Foster Child ☐Grandchild ☐DHS Custody ☐Other_____

Insurance Information

Primary Insurance_____

Last Name_____ **First Name**_____ **Soc. Sec. #** _____-____-_____

Address same as Patient ☐ **If Not: Address**_____ **City**_____ **State**_____ **Zip**_____

Date of Birth_____ **Gender:** ☐Male ☐Female **Phone #**_____ **Employer**_____

Secondary Insurance_____

Last Name_____ **First Name**_____ **Soc. Sec. #** _____-____-_____

Address same as Patient ☐ **If Not: Address**_____ **City**_____ **State**_____ **Zip**_____

Date of Birth_____ **Gender:** ☐ Male ☐ Female **Phone #**_____ **Employer**_____

Continue on back →

Gender Identity

☐ **None** ☐ **Identifies as Female** ☐ **Male** ☐ **Female to Male** ☐ **Male to Female**

☐ **Genderqueer neither exclusively Male nor Female**

☐ **Additional gender category or other please specify** _____

☐ **Choose not to disclose**

Sexual Orientation

☐ **None** ☐ **Lesbian, Gay or Homosexual** ☐ **Straight or Heterosexual** ☐ **Bisexual** ☐ **Don't Know**

☐ **Something else, please describe** _____

☐ **Choose not to disclose**

Living Situation

Do you consider yourself homeless? ☐Yes ☐No

If yes, what definition would best describe your living situation?

☐ Shelter ☐ Street ☐ Doubled Up (Temporarily living with others.)

☐ Transitional Housing (Temporary housing and supportive services to transition from homeless to permanent housing.)

☐ Other (Single room occupancy hotels/motels, day to day paid for housing, etc.) _____

Please Select Your Household Size and Your Estimated Yearly Gross Household Income:

Household Size	Yearly	Yearly	Yearly	Yearly	Yearly
1	☐ 0-$13,590	☐ $13,591-$19,026	☐ $19,027-$23,556	☐ $23,557-$27,180	☐ $27,181+
2	☐ 0-$18,310	☐ $18,311-$25,634	☐ $25,635-$31,737	☐ $31,738-$36,620	☐ $36,621+
3	☐ 0-$23,030	☐ $23,031-$32,242	☐ $32,243-$39,919	☐ $39,920-$46,060	☐ $46,061+
4	☐ 0-$27,750	☐ $27,751-$38,850	☐ $38,851-$48,100	☐ $48,101-$55,500	☐ $55,501 +
5	☐ 0-$32,470	☐ $32,471-45,458	☐ $45,459-$56,281	☐ $56,282-$64,940	☐ $64,941+
6	☐ 0-$37,190	☐ $37,191-$52,066	☐ $52,067-$64,463	☐ $64,464-74,380	☐ $74,381+
7	☐ 0-$41,910	☐ $41,911-$58,674	☐ $58,675-$72,644	☐ $72,645-$83,820	☐ $83,821+
8	☐ 0-$46,630	☐ $46,631-$65,282	☐ $65,283-$80,825	☐ $80,826-$93,260	☐ $93,261+
9	☐ 0-$51,350	☐ $51,351-$71,890	☐ $71,891-$89,007	☐ $89,008-$102,700	☐ $102,701+
10	☐ 0-$56,070	☐ $56,071-$78,498	☐ $78,499-$97,188	☐ $97,189-$112,140	☐ $112,141+
11	☐ 0-$60,790	☐ $60,791-$85,106	☐ $85,107-$105,369	☐ $105,370-$121,580	☐ $121,581+
12+	☐ 0-$65,510	☐ $65,511-$91,714	☐ $91,715-$113,551	☐ $113,552-$131,020	☐ $131,021+

Payment Agreement: I hereby certify that the above information is true. I understand that I am expected to promptly and fully pay for services provided by River Hills Community Health Center according to the fees established including co-pays and deductibles.

Assignment of Benefits: I hereby assign and authorize direct payment to River Hills Community Health Center of all insurance coverage or other benefits under any government program, any insurance policy or plan, or any other available benefit. This assignment shall remain in effect until revoked in writing.

Consent to Medical Treatment: I hereby request and give consent for the health care professionals at River Hills Community Health Center to provide medical treatment to me and/or my family.

Consent to Dental Treatment: I hereby request and give consent for the dental care professionals at River Hills Community Health Center to provide dental treatment to me and/or my family to include exam, radiographs, prophylaxis and application of fluoride.

Consent to Release Protected Health Information: I authorize River Hills Community Health Center to release medical information relating to the patient to health insurance companies, health plans or third party payors, or their authorized agents, for the purpose of determining benefits payable in connection with services provided.

X _____ _____ _____

Patient or Responsible Party Signature ***Relationship to Patient*** ***Date***

Continued on next page…

Patient Name: _____ **Date of Birth:** _____

Notice Of Privacy Practices Acknowledgement

I understand that, under HIPAA laws, I have certain rights to privacy regarding my health information. I understand that this information can and will be used for: Treatment, Payment, and Healthcare Operations. I have received, read and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand this does not include the release of records.

X _____ _____ _____

Patient or Responsible Party Signature ***Relationship to Patient*** ***Date***

HIPAA Approved Contacts

I hereby give permission to River Hills Community Health Center to disclose health and/or billing information to the individuals identified below that are involved in my care or payment of care.

Name_____ **Relationship**_____ **Phone** #_____

Name_____ **Relationship**_____ **Phone** #_____