



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 Registration Form

Patient Information

Last Name First Name MI Soc. Sec. # Address Apt/Unit City State Zip County Date of Birth Gender Male Female Phone: Home Cell Email

Marital Status: Single Married Divorced Widowed Separated
Employment Status: Full-time Part-time Self-employed Retired Unemployed
Student Status: Full-time Part-time NA

Military Status: Active Retired Veteran NA
Race (Please choose one): White Black/African American American Indian Native Asian Indian Chinese Filipino Japanese Korean Vietnamese Other Asian Native Hawaiian Other Pacific Islander Samoan Guamanian or Chamorro

Ethnicity (Please choose one): Non-Hispanic/Latino - Hispanic (Please choose one): Mexican Mexican American Chicano Puerto Rican Cuban Other Hispanic/Latino Origin

Primary Language: English Spanish Other
Are Interpretation Services Needed? Yes No

Employer: Occupation: Do you currently receive public housing? Yes No

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 Notf 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

Identifies as: None Female Male Female to Male Male to Female

Gender-queer 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	<input type="checkbox"/> 0-\$15,060	<input type="checkbox"/> \$15,061-\$21,084	<input type="checkbox"/> \$21,085-\$26,104	<input type="checkbox"/> \$26,105-\$30,120	<input type="checkbox"/> \$30,121 +
2	<input type="checkbox"/> 0-\$20,440	<input type="checkbox"/> \$20,441-\$28,616	<input type="checkbox"/> \$28,617-\$35,429	<input type="checkbox"/> \$35,430-\$40,880	<input type="checkbox"/> \$40,881 +
3	<input type="checkbox"/> 0-\$25,820	<input type="checkbox"/> \$25,821-\$36,148	<input type="checkbox"/> \$36,149-\$44,755	<input type="checkbox"/> \$44,756-\$51,640	<input type="checkbox"/> \$51,641 +
4	<input type="checkbox"/> 0-\$31,200	<input type="checkbox"/> \$31,201-\$43,680	<input type="checkbox"/> \$43,681-\$54,080	<input type="checkbox"/> \$54,081-\$62,400	<input type="checkbox"/> \$62,401 +
5	<input type="checkbox"/> 0-\$36,580	<input type="checkbox"/> \$36,581-\$51,212	<input type="checkbox"/> \$51,213-\$63,405	<input type="checkbox"/> \$63,406-\$73,160	<input type="checkbox"/> \$73,161 +
6	<input type="checkbox"/> 0-\$41,960	<input type="checkbox"/> \$41,961-\$58,744	<input type="checkbox"/> \$58,745-\$72,731	<input type="checkbox"/> \$72,732-\$83,920	<input type="checkbox"/> \$83,921 +
7	<input type="checkbox"/> 0-\$47,340	<input type="checkbox"/> \$47,341-\$66,276	<input type="checkbox"/> \$66,277-\$82,056	<input type="checkbox"/> \$82,057-\$94,680	<input type="checkbox"/> \$94,681 +
8	<input type="checkbox"/> 0-\$52,720	<input type="checkbox"/> \$52,721-\$73,808	<input type="checkbox"/> \$73,809-\$91,381	<input type="checkbox"/> \$91,382-\$105,440	<input type="checkbox"/> \$105,441 +
9	<input type="checkbox"/> 0-\$58,100	<input type="checkbox"/> \$58,101-\$81,340	<input type="checkbox"/> \$81,341-\$100,707	<input type="checkbox"/> \$100,708-\$116,200	<input type="checkbox"/> \$116,201 +
10	<input type="checkbox"/> 0-\$63,480	<input type="checkbox"/> \$63,481-\$88,872	<input type="checkbox"/> \$88,873-\$110,032	<input type="checkbox"/> \$110,033-\$126,960	<input type="checkbox"/> \$126,961 +
11	<input type="checkbox"/> 0-\$68,860	<input type="checkbox"/> \$68,861-\$96,404	<input type="checkbox"/> \$96,405-\$119,357	<input type="checkbox"/> \$119,358-\$137,720	<input type="checkbox"/> \$137,721 +
12+	<input type="checkbox"/> 0-\$74,240	<input type="checkbox"/> \$74,241-\$103,936	<input type="checkbox"/> \$103,937-\$128,683	<input type="checkbox"/> \$128,684-\$148,480	<input type="checkbox"/> \$148,481 +

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...

(MONTH, DAY, YEAR)

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 # _____

EMERGENCY CONTACT

This person will only be contacted as another way to try to reach the patient. No Medical or Billing information can be given to this person unless they are also listed as a HIPAA contact (above).

Name _____ Relationship _____ Phone # _____