RIVERHILLS COMMUNITY HEALTH CENTER

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 (MONTH,DAY,YEAR)____/____/____ 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

Race: (Please choose one):___White___Black/African American_American Indian_Native Asian Indian
__ Chinese__FilipinoJapanese___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_(Month, Day, Year)____/____/_____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(Month/Date/Year) ___/____/_____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(Month/Day/Year):____/____/_____Gender: __Male __Female Phone #_____

Employer_____

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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 permanenthousing.)

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

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

For our federal grant reporting purposes we are required to track the income of our patients, however we do not include your personal information.
This section is not for the purpose of applying for the Sliding fee Discount Program.

Yearly Gross Annual Income:$_____ Family Size_____

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 the above listed health insurance company(s), for the purpose of determining benefits payable in connection with services provided. I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

X

_____	_____	_____
Patient or Responsible Party Signature	***Relationship to Patient***	***Date (Month, Day, Year)***

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 (Month, Day, Year)***

Continued on next page

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

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 #**_____

EMERGENCYCONTACT

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 #_____