Established Patient Registration Form

FAMILY MEDICINE HEALTH CENTER

Family Medicine Health Center (FMHC) is a Federally Qualified Health Center and receives federal funding pursuant to Section 330 of the Public Health Service Act. We are required to collect information about age, gender, race, sexual orientation, income, and family size for statistical purposes only. No individual information is submitted.

ESTABLISHED PATIENT INFORMATION

Last Name:	First Name:	M.I.:	Birth Date: / /

Family Size (Including Self:

Annual Household Income:

Farmworkers:

Has anyone in your household worked in agriculture (fields, orchards, etc.) in the past 2 years? ☐ Yes ☐ No

If yes, did that person work for less than 12 months out of the year? ☐ Yes ☐ No

If yes, did that person move from place to place for work? ☐ Yes ☐ No

Is anyone in your household a retired farmworker? ☐ Yes ☐ No

Living Status:

☐ Own ☐ Doubling Up
☐ Rent ☐ Street
☐ Public Housing ☐ Unknown
☐ Homeless Shelter ☐ Other:
☐ Transitional

For each statement, please tell me whether the statement was "often true, sometimes true, or never true" for your household:

A. "Within the past 12 months we worried whether our food would run out before we got money to buy more."

① *often true* ②. *sometimes true* ③ *never true* ④ *don't know, or refused*

B. "Within the past 12 months the food we bought just didn't last and we didn't have money to get more."

① *often true* ②. *sometimes true* ③ *never true* ④ *don't know, or refused*

IN CASE OF EMERGENCY

Name of Local Friend or Relative:(not living at same address)	Relationship to Patient:	Phone Number:	Alternate Phone Number:

AUTHORIZATION TO BILL INSURANCE AND ASSIGNMENT OF BENEFITS

The above information is true to the best of my knowledge. I authorize FMHC to directly bill my insurance company and I further authorize any third-party payer through which I have benefits to make payment directly to FMHC. I understand that I am financially responsible for any balance. I also authorize Family Medicine Health Center or insurance company to use and disclose any healthcare information for the purpose of obtaining payment for services and determining insurance benefits. Services provided by outside companies, (i.e., lab, pathology, radiology) are billed separately by those companies.

X _____ X _____

Patient/Guardian Signature *Date*

FINANCIAL RESPONSIBILITY | SIGNATURE ON FILE

I understand that I am financially responsible for the payment of medical charges incurred on my behalf at Family Medicine Health Center, including charges that are not paid in full by my insurance, government program benefits, or other third-party payers. I also agree to pay or reimburse FMHC for all costs it may incur in collecting such amounts, including, but not limited to, attorneys' fees and collection agency fees. Services provided by outside companies, (i.e., lab, pathology, radiology) are billed separately by those companies.

X _____ X _____

Patient Signature *Date*

If patient is not the individual signing:

☐ Patient is under 18 years of age and considered a minor ☐ Patient is physically or mentally incompetent ☐ Other:

X _____ X _____

Patient/Guardian Signature Relationship to Patient: *Date*

X _____ X _____

Witness Signature *Date*

NOTE: MEDICARE RECIPIENTS NEED TO SIGN THE NEXT SECTION

Medicare/Medigap Authorization: I request that payment of authorized Medicare/Medigap benefits be made either to me or on my behalf to Family Medicine Health Center for any services furnished me by FMHC. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services, or its intermediaries or carriers, any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Name of Beneficiary Medicare Policy Number

X _____ X _____

Patient/Guardian Signature *Date*

MEDICARE SECONDARY

☐ Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
☐ Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
☐ Medicare Secondary, Other Liability Insurance is Primary
☐ Medicare Secondary, No-fault Insurance including Auto is Primary
☐ Medicare Secondary Worker's Compensation
☐ Medicare Secondary Veteran's Administration
☐ Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month coordination period with an employer's group health plan
☐ Medicare Secondary Public Health Service (PHS) or Other Federal Agency
☐ Medicare Secondary Black Lung

FAMILY MEDICINE HEALTH CENTER

CONSENT FOR OUTPATIENT TREATMENT

This form includes important information about how care is provided to patients at Family Medicine Health Center ("Health Center"). Patients and parents, guardians, and other patient representatives should read this information carefully or ask for assistance to have the form read to you. By signing this form, you agree to receive care at the Health Center according to the following terms and conditions:

1. Consent. I request and authorize the Health Center and its physicians, residents, assistants and designees to provide the medical care and treatment necessary or advisable to me, or the patient identified below. This care may include, but is not limited to, routine diagnostic radiology and laboratory procedures, administration of routine drugs, biologicals and other therapeutics, and routine medical and nursing care.

2. Emergencies. I authorize the Health Center to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my, or the patient's, life or health.

3. Risks and Benefits. I am aware that the practice of medicine is not an exact science and I understand that the Health Center is not making any guarantees or promises about the results of the care received.

4. Health Changes. I understand that it is my responsibility to tell the Health Center if there are any significant change in my, or the patient's, physical or emotional condition.

5. Testing. I understand that samples of body fluids and/or tissues may be withdrawn during tests and procedures. I authorize the Health Center and its affiliates to perform other tests on these body fluids and/or tissues in order to further treatment, medical research and knowledge and/or to dispose of these fluids and tissues.

6. Medication Verification. I authorize the Health Center to contact healthcare providers from whom I, or the patient, have received treatment to obtain medical information and/or records, including but not limited to, commercial pharmacies (i.e. Walgreens, CVS, Costco, etc.), and alcohol and other drug treatment records for verification of my medications and treatment.

7. Transmittable Diseases. I have been informed and understand that HIV (human immunodeficiency virus)/AIDS, HCV (hepatitis C virus) and HbsAg (hepatitis Bvirus) tests may be performed on me, or the patient, without my consent if a health professional, facility employee or First Responder sustains an exposure to my, or the patient's, blood or other body fluid.

8. Personal Valuables. I understand that I am responsible for any and all personal valuables that I bring with me, or the patient, to the Health Center. I hereby release the Health Center and its agents from any liability for the loss or damage of any and all personal possessions which I choose to keep with me during my, or the patient's, care and treatment.

9. Residency Program. The Health Center is operated by the Family Medicine Residency of Idaho. Health Center patients are cared for by a medical team that includes a physician, a resident and a mid-level provider (PA, NP, and CNM). The physician and resident will be your primary providers. A resident "is a doctor who has received a medical degree (MD, DO) from an accredited medical school and who practices medicine under the supervision of a fully licensed physician, usually in a hospital or clinic". I consent to having a resident and student involved in my, or the patient's, care.

10. Acknowledgement of Privacy Practices. The Health Center's Notice of Privacy Practices provides information about how protected health information about patients may be used or disclosed for purposes of treatment, payment or the Health Center's operations. Information about communicable diseases and infections, including venereal disease, tuberculosis, hepatitis B, HIV (AIDS virus) and AIDS related complex, alcohol and drug abuse treatment information, mental health treatment records, and reports of abuse, abandonment or neglect may be used and disclosed under certain circumstances. I have been offered an opportunity to review the Notice before signing this consent. I understand that the terms of the Privacy Notice may change and that I may request a current copy from the Health Center at any time.

11. Attendance Policy. A copy of the Health Center's Attendance Policy has been made available to me. I understand it is my responsibility to know my, or the patient's, appointment dates and times and I understand that services may be discontinued in the event I, or the patient, do not attend scheduled appointments.

12. Ending Treatment. I understand that I have the right to terminate treatment at the Health Center at any time I choose to do.

I HAVE HAD THE OPPORTUNITY TO READ THIS FORM (OR HAVE IT READ TO ME), ASK QUESTIONS, AND HAVE THESE QUESTIONS ANSWERED.

_____ _____

Signature of Patient Date

_____

Print Patient Name

_____ _____

Signature of Legal Guardian if Patient is a Minor Date

_____ _____

Print Guardian Name Relationship to Patient