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.

PATIENT INFORMATION

Last Name:	First Name:	M.I.:	Marital Status: (Choose One) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐Widow(er)
Mailing Address:			Social Security No.:
City:	State:	Zip:	Home Phone: / Cell Phone:
E-Mail:	Employer:		Work Phone:

Contact for Reminder Calls and Other Electronically Generated Messages: (Choose One) ☐ Text ☐ Voice (Select Preferred Number: ☐ Home ☐ Cell ☐ Work)

Race: (Choose One)
☐ Asian
☐ Black/African American
☐ White/Caucasian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ American Indian
☐ Alaska Native
☐ Multi-Racial
☐ Refused to Report

Ethnicity: (Choose One)
☐ Hispanic/ Latino
☐ Not Hispanic/Latino
☐ Refused to Report

Birth Date: / /
MO / DAY / YR
AGE:
Birth Sex:
☐ Male
☐ Female

Gender Identity:
☐ Male
☐ Female
☐ Transgender Male: Female-to-Male
☐ Transgender Female: Male-to-Female
☐ Other
☐ Choose Not to Disclose

Sexual Orientation:
☐ Lesbian or Gay
☐ Straight
☐ Bisexual
☐ Something Else
☐ Don't Know
☐ Choose Not to Disclose

Veteran Status: ☐ Veteran ☐ Non-Veteran
Preferred Language:
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
☐ Rent
☐ Public Housing
☐ Homeless Shelter
☐ Transitional
☐ Doubling Up
☐ Street
☐ Unknown
☐ Other:

RESPONSIBLE PARTY

Person Responsible:	Birth Date: / /	Address (if different):	Home Phone:
Occupation:	Employer:	Employer Address:	Employer Phone:

Is this person a patient at FMHC? ☐ Yes ☐ No
Is this patient covered by insurance? ☐ Yes ☐ No

INSURANCE INFORMATION *(Please give your insurance card to the receptionist)*

Name of Primary Insurance: ☐ IPN ☐ Tricare ☐ Blue Cross ☐ Blue Shield ☐ Medicare ☐ Medicaid ☐ Other:

Primary Medical Insurance			Secondary Medical Insurance		
Subscriber's Name:	Subscriber's SSN:	Birth Date: / /	Subscriber's Name:	Subscriber's SSN:	Birth Date: / /
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐Child ☐ Friend ☐ Partner ☐ Dependant ☐ Parent ☐ Other			Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐Child ☐ Friend ☐ Partner ☐ Dependant ☐ Parent ☐ Other		

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*

CREDIT POLICY

PHILOSOPHY: It is the desire of Family Medicine Health Center (FMHC) to provide quality medical and behavioral health services without barriers to access. This policy guides us in providing access to care while also ensuring we collect amounts owed to us for the provision of services. For those patients with insurance coverage, we will properly bill insurance on a timely basis. If you do not have insurance coverage, we are sensitive to your financial constraints and do not want to impede access to care that is vital to your health. FMHC will work with its patients on payment plans to absolve account balances but requires that the patient stay engaged in this process and follows the terms that have been agreed to.

PROCEDURE:

1. We will request payment at the time of service. If you are unable to pay the adjusted amount due at the time of appointment, we will ask that you pay what you can and FMHC will bill you the balance.
2. If you receive an account statement from us and cannot pay the entire balance, we request that you contact us within 30 days about a satisfactory payment plan to resolve the amounts due.
3. If you have not made any payments on your account and have not agreed to a payment plan to resolve the balance within 30 days, you will receive a notice that your account may be referred to an outside collection agency.
4. If you have not attempted to resolve your account with payment nor communicate with us regarding a payment plan, a final notification will be sent to your last known address informing you that your account is being referred to an outside collection agency. At the time your account is listed with the collection agency, your credit record may be adversely affected.

It is the experience of Family Medicine Health Center that the vast majority of our patients understand and cooperates with our long standing credit policy. Family Medicine Health Center is disclosing our policy to you now, so that we may avoid any misunderstanding in the future. By signing below, you acknowledge that you have read, understand and agree to comply with this credit policy.

X _____ X _____

Patient/Guardian Signature *Date*

MISSED APPOINTMENT OR NO SHOW POLICY

This policy enables us to better utilize available appointments for our patients in need of medical care. Office time is valuable and when patients miss an appointment without calling to cancel or reschedule with adequate notice we are unable to see other patients in that time slot. We understand that circumstances sometimes arise that makes it difficult to come to an appointment, e.g. lack of transportation etc. We have social workers that can assist if special circumstances arise. Patients must call promptly if they are unable to attend an appointment. If it is necessary to cancel your scheduled appointment we request that you call at least 24-hours before your scheduled appointment. While we make multiple efforts to confirm your appointment, patients who fail to keep a scheduled appointment without notifying the office before the appointment will be recorded as a no-show. **Patients who have three (3) no-shows in six (6) consecutive months WILL NOT be allowed to preschedule routine appointments. Patients will be able to come to same day or acute appointments ONLY**. Prescriptions will continue to be written for fill from the pharmacy. After six (6) months of being in "same day" appointment status with no concerns, the patient will again be able to pre-schedule routine appointments.

LATE TO APPOINTMENT POLICY

If you are an established patient and you arrive 15 minutes or more, late to your appointment you may be asked to reschedule unless the physician's schedule can still accommodate you. Priority will be given to patients who arrive on time and you may have to be worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule. If you are a new patient and you arrive at the scheduled appointment time and not early to complete your forms as instructed and it takes more than 15 minutes to complete the forms and the registration process, you may also be asked to reschedule. We ask that you please be courteous of your provider's valuable time and attention. The physicians, office staff, as well as your fellow patients will thank you.

NOTICE OF PRIVACY PRACTICES, NO SHOW POLICY, AND COMPLAINT PROCEDURE PATIENT ACKNOWLEDGEMENT FORM

- The Family Medicine Health Center's **Notice of Privacy Practices** describes how patient's medical information may be used and disclosed and outlines your rights regarding this protected information.
- The Family Medicine Health Center's **No Show Policy** describes the number of No Shows a patient can encounter before termination occurs.
- The Family Medicine Health Center's **Complaint Procedure** enables patients to file a complaint regarding their medical treatment, the FMHC billing practices or the general operating policies of FMHC. Patients may submit written complaints.

Your signature indicates that you have read, understand and acknowledge FMHC's Notice of Privacy Practices, No Show Policy, and Complaint Procedure.

Patient Name Legibly Written (First, Middle Initial, Last) _____ Date of Birth _____

X _____ X _____

Patient/Guardian Signature *Date*

FOR FMHC STAFF USE ONLY

If the patient or guardian refuses to sign/complete this form, please complete this section. Date offered to patient: ____/____/_____ FMHC Staff Initials:_____

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