Annual Registration **Family Health Center**

Patient Information

Last Name_____First Name_____Middle Name_____

Address_____Apt#_____

City_____State_____Zip_____

BirthDate_____SSN_____Patient / Guardian E-Mail_____

Home Phone_____Cell Phone_____Employer_____Work Phone_____

Emergency Contact_____Relationship to patient_____Phone_____

Preferred Communication Method: ☐ Phone ☐ Email (MyChart) ☐ US Mail Preferred Pharmacy_____

SEX AT BIRTH: ☐ Male ☐ Female

GENDER IDENTITY
☐ MALE ☐ FEMALE ☐ OTHER ☐ CHOOSE NOT TO DISCLOSE
☐ TRANSGENDER MALE / FEMALE TO MALE

SEXUAL ORIENTATION
☐ STRAIGHT (NOT LESBIAN OR GAY)
☐ LESBIAN ☐ GAY ☐ BISEXUAL
☐ SOMETHING ELSE ☐ DON'T KNOW
☐ CHOOSE NOT TO DISCLOSE

PREFERRED LANGUAGE
☐ ENGLISH
☐ SPANISH
☐ SIGNING / ASL
☐ OTHER_____

VETERAN STATUS
☐ ACTIVE DUTY
☐ DISCHARGED (VETERAN)
☐ NATIONAL GUARD
☐ RESERVES ☐ NONE

ETHNICITY
☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO

RACE
☐ WHITE ☐ BLACK OR AFRICAN AMERICAN
☐ ASIAN ☐ AMERICAN INDIAN OR ALASKAN NATIVE
☐ NATIVE HAWAIIAN ☐ OTHER PACIFIC ISLANDER

MARITAL STATUS
☐ SINGLE
☐ MARRIED
☐ WIDOWED
☐ DIVORCED

HOUSEHOLD INFORMATION
HOW MANY PEOPLE ARE IN YOUR HOUSEHOLD INCLUDING YOURSELF? _____
WHAT IS YOUR MONTHLY HOUSEHOLD INCOME?
☐ I HAVE NO INCOME ($0)
☐ MY MONTHLY INCOME IS $_____
☐ MY YEARLY INCOME IS $_____

FARM WORKER STATUS
☐ MIGRATORY FARM WORKER
☐ SEASONAL FARM WORKER
☐ NOT A FARM WORKER

IN PUBLIC HOUSING ☐ YES ☐ NO

HOMELESS STATUS
☐ DOUBLED UP (LIVING WITH OTHERS)
☐ IN A HOMELESS SHELTER
☐ TRANSITIONAL HOUSING
☐ ON THE STREET
☐ PERMANENT SUPPORTIVE HOUSING (THROUGH MHMR / FAMILY ABUSE CENTER)

PARENT / GUARDIAN / GUARANTOR (FINANCIALLY RESPONSIBLE PERSON) INFORMATION

NAME_____BIRTHDATE_____SSN_____

ADDRESS ☐ CHECK IF SAME AS ABOVE_____

CITY_____STATE_____ZIP_____CELL PHONE_____

WORK PHONE_____HOME PHONE_____EMPLOYER_____

RELATIONSHIP TO PATIENT ☐ MOTHER ☐ FATHER ☐ GRANDPARENT ☐ FOSTER PARENT ☐ OTHER_____

PRIMARY
MEDICAL INSURANCE NAME_____Member ID #_____GROUP #_____

IS THE POLICY HOLDER THE PATIENT? ☐ YES ☐ NO (IF NO, PLEASE COMPLETE THIS SECTION) POLICY HOLDER INFORMATION: NAME_____

☐ MALE ☐ FEMALE BIRTHDATE_____SSN_____RELATIONSHIP TO PATIENT_____

ADDRESS ☐ CHECK IF SAME AS ABOVE CITY STATE ZIP

SECONDARY
MEDICAL INSURANCE NAME_____Member ID #_____GROUP #_____

IS THE POLICY HOLDER THE PATIENT? ☐ YES ☐ NO (IF NO, PLEASE COMPLETE THIS SECTION) POLICY HOLDER INFORMATION: NAME_____

☐ MALE ☐ FEMALE BIRTHDATE_____SSN_____RELATIONSHIP TO PATIENT_____

ADDRESS ☐ CHECK IF SAME AS ABOVE CITY STATE ZIP

IF YOU WOULD LIKE TO BE CONTACTED FOR A DENTAL APPOINTMENT PLEASE COMPLETE THIS SECTION

DENTAL INSURANCE NAME_____Member ID #_____GROUP #_____

IS THE POLICY HOLDER THE PATIENT? ☐ YES ☐ NO (IF NO, PLEASE COMPLETE THIS SECTION) POLICY HOLDER INFORMATION: NAME_____

☐ MALE ☐ FEMALE BIRTHDATE_____SSN_____RELATIONSHIP TO PATIENT_____

ADDRESS ☐ CHECK IF SAME AS ABOVE_____CITY_____STATE_____ZIP_____

WORK PHONE_____HOME PHONE_____CELL PHONE_____

(Rev. 201208)

General Consent to Treat and Acknowledgement of Teaching Services

I hereby consent to any and all treatment that my Family Health Center (hereinafter "FHC") clinician and I agree is necessary for me or for the patient(s) I am guardian for.

I understand and acknowledge that FHC is a teaching center, and my care, and/or the care of patients(s) I am guardian for, at FHC may be provided by a clinician, including but not limited to medical students and/or resident physicians and/or resident dentists, in a clinical training program. I further understand and acknowledge that teaching services such as direct observation by other physicians or medical students, case discussions, or photographic or video images of care activities involving me or my dependents are allowed for teaching purposes unless specifically denied by me. I understand and acknowledge that certain clinical visits may be delivered by telehealth (video or telephone) services, during which I will not be physically in the same room as my provider. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties. If it is determined that the telecommunications or information technology is not adequate, my telehealth visit may be discontinued or converted into an in-person visit.

I further understand that as part of its health care services, FHC's personnel and my clinician create and maintain a record of care and services provided. I understand that such information may be used and/or disclosed in the management and delivery of care and services provided by FHC, as described in the Notice of Privacy Practices. I understand and acknowledge that FHC Participates in an electronic health record exchange program, and that if I seek treatment from other healthcare facilities or providers participating in this exchange program, my health information, or that of the patient(s) I am guardian for, may be shared between FHC and those other facilities or providers. I understand and acknowledge that as part of receiving my healthcare at FHC, FHC's clinicians and other personnel may electronically request and/or provide health records for me and/or patient(s) I am guardian for, to those participating facilities or providers. These records include, but are not limited to prescription medication history, as well as information related to mental health treatment, alcohol and/or drug abuse diagnosis, prognosis and treatment, and/or HIV (AIDS) testing/results and/or treatment. I further understand that any such information from any source whatsoever may become part of the requesting party's health records on me and/or the patient(s) I am guardian for.

NOTICE OF PRIVACY PRACTICES

I hereby understand that I have the right to request a copy of the Family Health Center's Notice of Privacy Practices.

LIMITED ENGLISH PROFICIENCY

The Family Health Center proudly offers certain language assistance to its patients free of charge. We also strive to make reasonable accommodations for its disabled patients.

PHOTOGRAPHY

I consent to the taking of photographic and/or video images for the purpose of identification and documentation of my medical care.

STATEMENT OF FINANCIAL RESPONSIBILITY

I hereby understand I am the person primarily responsible for payment of all charges for services rendered by FHC, regardless of any insurance coverage I might have, including Medicare or Medicaid, and that such payment is due on demand. I further understand that in addition to such service charges, I will be liable for any court costs, attorney's fees, collection expense, or interest that may be incurred should such actions be required to obtain payment for services rendered by FHC. I certify that the patient and financial information given at the time of services rendered is accurate and complete.

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of service rendered, I hereby irrevocably assign and transfer to FHC, all rights, title and interest in benefits payable for services rendered by FHC. I hereby authorize and instruct the insurance company and/or Financial Program to pay directly to FHC all benefits due under the terms of my policy or policies. I understand that my insurance policy/financial program, or their health-insuring agent(s), determine the medical necessity of services/items I request and receive. I also understand that I am responsible for payment of services or items I request and receive if these services/items are determined by my insurance policy/financial program not to be reasonable and medically necessary for my care.

OUTSIDE DIAGNOSTIC CHARGES

Laboratory testing for specimens/x-rays/CT/ultrasounds obtained at FHC and sent to a radiologist or independent lab will be billed to me directly from that independent facility. There is also a lab handling fee for obtaining lab specimen(s) which is billed through FHC. Upon receiving a statement, I understand that I am to contact that laboratory or radiology company to arrange payment or exchange insurance information. I have been informed in writing and verbally of this. I understand that these diagnostic charges are now my responsibility.

PATIENT /GUARDIAN SIGNATURE

I have read and understand the aforementioned document.

PATIENT SIGNATURE _____ DATE _____

PARENT/GUARDIAN* SIGNATURE _____RELATIONSHIP TO PATIENT _____

WITNESS _____

Legal guardian must provide proof of guardianship, a copy of which must be attached to this form.

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