Patient Registration Form

Please present this Form with your insurance card and Photo ID

Complete entire form. For areas that do not apply to the patient enter "N/A".

Patient's Name			**Date of Birth:**	
Social Security Number:				
Mailing Address Street and Apartment Number	City	State	Zip	County
Physical Address Street and Apartment Number ☐ Same as mailing	City	State	Zip	County

1st Phone ☐ **Cell** ☐ **Home** ☐ **Work** OK to Leave Message ☐ Yes ☐ No	**2ndPhone** ☐ **Cell** ☐ **Home** ☐ **Work** OK to Leave Message ☐ Yes ☐ No
Email Address **Receive secure email message opt out** ☐ **Yes**	**Text Message (enter phone number)** **Receive text message opt out** ☐ **Yes**

Marital Status:
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Emergency Contact Name	Relationship	☐ Cell Phone ☐ Home Phone ☐ Work

Do you have Medical or Dental Insurance? Please present your insurance card to the Medical Receptionist.
☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☐ Other
☐ No Insurance

Primary Medical Insurance Plan	**Policy Number**
Secondary Medical Insurance Plan	**Policy Number**
Dental Insurance Plan	**Policy Number**

Parent or Guardian Name First MI Last

☐ **Same as Patient** **Parent or Guardian Date of Birth / /**

Parent/Guardian Address Street City State Zip Code

Parent/Guardian Employer Name	**Parent Guardian Work Phone**

How did you hear about us? ☐ Family/Friend ☐ Shelter ☐ Health Department ☐ Hospital
☐ Social Services ☐ Media ☐ Other

Race (check all that apply)	**Ethnicity**	**Sexual Orientation**	**Gender Identity**
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Declined to Answer	☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Declined to Answer **Preferred Language** ☐ English ☐ Spanish ☐ Chinese ☐ Arabic ☐ Vietnamese ☐ Other **Are interpreter services needed?** ☐ Yes ☐ No	☐ Straight/not Lesbian or Gay ☐ Lesbian or Gay ☐ Bisexual ☐ Unknown ☐ Declined to Answer	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Other ☐ Declined to Answer

Do you live in Public Housing? ☐ Yes ☐ No

Are you a Veteran? ☐ Yes ☐ No

Homeless Status ☐ **Not Homeless** ☐ **Shelter** (organized shelter)

☐ **Street** (living outdoors, encampment, care, makeshift housing)

☐ **Doubling Up** (person who is living with others; arrangement generally considered temporary and unstable)

☐ **Permanent Supportive Housing** (Persons transitioning from homelessness to permanent or housing support programs within the last 12 months)

☐ **Transitional Housing** (transitioning from a homeless environment, do not include jail, institutional treatment programs, military, schools or other institutions)

☐ **Yes** ☐ **No** **Migrant Farm Worker** – Individual who is required to be absent from a permanent place of residence for the purpose of seeking remunerated employment in agricultural work

☐ **Yes** ☐ **No** **Seasonal Farm Worker** – Individual who is employed in temporary farm work but do NOT move from their permanent residence to seek work; they may also have other sources of employment.

Please circle the range below indicating the estimated annual household income of the patient according to the number of people living in the patient's home. Advance Community Health is required to report this information to the Federal government, and it helps us to better understand the needs of the communities we served. No identifying information shall be disclosed to the federal government. Your anonymity is protected.

NUMBER OF PEOPLE LIVING IN HOUSEHOLD	ANNUAL HOUSEHOLD INCOME			
1	*$0 – $13,590* ☐	*$13,591 - $20,385* ☐	*$20,386 - $27,180* ☐	*More than $27,180* ☐
2	*$0 – $18,310* ☐	*$18,311 - $27,465* ☐	*$27,466 - $36,620* ☐	*More than $36,620* ☐
3	*$0 – $23,030* ☐	*$23,031 - $34,545* ☐	*$34,546- $46,060* ☐	*More than $46,060* ☐
4	*$0 – $27,750* ☐	*$27,751 - $41,625* ☐	*$41,626 - $55,500* ☐	*More than $55,500* ☐
5	*$0 – $32,470* ☐	*$32,471 - $48,705* ☐	*$48,706 - $64,940* ☐	*More than $64,940* ☐
6	*$0 – $37,190* ☐	*$37,191 - $55,785* ☐	*$55,786 - $74,380* ☐	*More than $74,380* ☐

Would you like information on our Sliding Fee Discount Program? ☐ **Yes** ☐ **No**

Advance Community Health

Patient Registration Disclosures and Consent

Patient Name: **Date of Birth:**

Assignment of Insurance Benefits:

I hereby authorize direct payment of my insurance benefits to Advance Community Health for services rendered to my dependents or me by the practitioner. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Advance Community Health is unable to collect from by the insurance carrier for whatever reason.

Health Insurance Portability and Accountability Act "HIPAA":

I hereby authorize the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations. I understand the identity of designated parties must be verified before the release of any information. I also understand these parties will have access of all of my protected health information including substance abuse, mental health, STI, AIDS and HIV records.

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Authorization to Mail, Call, Email or Text:

I certify that I understand the privacy risks of the mail, phone call, email and text. I hereby authorize Advance Community Health or my practitioner to mail, call, email or text me with communications regarding my healthcare, including by not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Advance Community Health to that effect in writing.

Authorization to Release Non-Public Personal Information:

I certify that I have received and read a copy of Advance Community Health Privacy Practice of the date on the signature below. I hereby authorize Advance Community Health to release any of my or my dependents medical or incidental non-public protected health information as described in the privacy practices that may be necessary for medical evaluation, treatment, consultation or the processing of insurance benefits. I understand that I retain the rights granted to me through Advance Community Privacy Practices. I hereby consent to Advance Community Health's Privacy Practices.

Lab/X-Ray/Diagnostic Services

I understand that I may receive a separate bill if my medical care includes lab, x-ray or other diagnostic services. I further understand that I am financial responsible for co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

Consent to Treatment:

I hereby consent to evaluation, testing, and treatment as directed by Advance Community Health physician and or practitioner.

Patient Signature or Mark: _____ **Date:** _____

Patient/Guardian Signature: _____ **Date:** _____

Patient/Parent/Guardian: _____ **Date:** _____

(Please Print Name)

Employee Witness Signature: _____ **Date:** _____

Revised 04/01/2022