RIVERHILLS COMMUNITY HEALTH CENTER

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 Registration Form

Patient Information

Last Name_____ First Name_____ MI____ Soc. Sec. # _____ - ___ - _____

Address_____Apt/Unit_____City_____State_____

Zip_____County_____ Date of Birth___/____/___ 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 __NA

Race (Please choose one): __ White __Black/African American __American Indian __Native __Asian Indian __Chinese __Filipino __Japanese __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**_____ **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_____ **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_____ **Gender: __**Male __Female **Phone #**_____ **Employer**_____

Continue on back →

Gender Identity

___None ___Identifies as Female ___Male ___Female to Male ___Male to Female

___Gender-queer neither exclusively Male nor Female

___Additional gender category or other please specify_____

___Choose not to disclose

Sexual Orientation

___None ___Lesbian, Gay or Homosexual ___Straight or Heterosexual ___Bisexual ___Don't Know

___Something else, please describe _____

___Choose not to disclose

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 permanent housing.)

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

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

Household Size	Yearly	Yearly	Yearly	Yearly	Yearly
1	☐0-$15,060	☐$15,061-$21,084	☐ $21,085-$26,104	☐$26,105-$30,120	☐$30,121 +
2	☐0-$20,440	☐$20,441- $28,616	☐ $28,617-$35,429	☐$35,430-$40,880	☐$40,881 +
3	☐0-$25,820	☐ $25,821-$36,148	☐ $36,149-$44,755	☐$44,756-$51,640	☐$51,641
4	☐0-$31,200	☐ $31,201-$43,680	☐$43,681-$54,080	☐$54,081-$62,400	☐$62,401 +
5	☐0-$36,580	☐$36,581-$51,212	☐$51,213-$63,405	☐$63,406-$73,160	☐$73,161 +
6	☐0-$41,960	☐$41,961-$58,744	☐ $58,745-$72,731	☐$72,732-$83,920	☐ $83,921 +
7	☐0-$47,340	☐$47,341-$66,276	☐ $66,277-$82,056	☐$82,057-$94,680	☐$94,681 +
8	☐0-$52,720	☐$52,721-$73,808	☐ $73,809-$91,381	☐$91,382-$105,440	☐$105,441 +
9	☐0-$58,100	☐$58,101-$81,340	☐$81,341-$100,707	☐$100,708-$116,200	☐$116,201 +
10	☐0-$63,480	☐$63,481-$88,872	☐$88,873-$110,032	☐ $110,033-$126,960	☐$126,961 +
11	☐0-$68,860	☐$68,861-$96,404	☐$96,405-$119,357	☐$119,358-$137,720	☐$137,721 +
12+	☐0-$74,240	☐$74,241-$103,936	☐$103,937-$128,683	☐ $128,684-$148,480	☐$148,481 +

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 health insurance companies, health plans or third party payors, or their authorized agents, for the purpose of determining benefits payable in connection with services provided.

X _____ _____ _____

Patient or Responsible Party Signature ***Relationship to Patient*** ***Date***

Continued on next page…

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

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***

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** #_____

EMERGENCY CONTACT

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 #_____