



PATIENT REGISTRATION FORM

FULL NAME			
SSN#	DATE OF BIRTH (MM/DD/YY)	GENDER AT BIRTH <input type="checkbox"/> M <input type="checkbox"/> F	
ADDRESS	CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ADDRESS)	MAILING CITY	MAILING STATE	MAILING ZIP CODE
HOME PHONE	CELL PHONE	WORK PHONE	
ADDITIONAL/FORMER NAMES (EX. MAIDEN NAME)		MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	
EMAIL ADDRESS (REQUIRED FOR PATIENT PORTAL ACCESS)		Employer: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> PRN	
PHARMACY <input type="checkbox"/> Health Ministries Clinic Pharmacy <input type="checkbox"/> Other Pharmacy (specify): _____			

RACE <i>(Check all that apply)</i>	HOUSING <i>Are you currently experiencing homeless?</i>	GENDER IDENTITY
<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Male
<input type="checkbox"/> Asian	<input type="checkbox"/> No	<input type="checkbox"/> Female
<input type="checkbox"/> Black/African American	IF YES: are you utilizing any of the following?	<input type="checkbox"/> Transgender
<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Homeless Shelter	<input type="checkbox"/> Decline to Specify
<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Transitional	<input type="checkbox"/> Other (please specify): _____
<input type="checkbox"/> White	<input type="checkbox"/> Doubling Up	DO YOU LIVE IN PUBLIC HOUSING?
	<input type="checkbox"/> Street	<input type="checkbox"/> Yes
	<input type="checkbox"/> Other (please specify): _____	<input type="checkbox"/> No
DO YOU IDENTIFY AS HISPANIC/LATINO?	POPULATIONS <i>(Check all that apply)</i>	SEXUAL ORIENTATION
<input type="checkbox"/> Yes	<input type="checkbox"/> Veteran	<input type="checkbox"/> Lesbian/Gay
<input type="checkbox"/> No	<input type="checkbox"/> Farm Worker	<input type="checkbox"/> Straight
PREFERRED LANGUAGE	<input type="checkbox"/> Migrant Worker	<input type="checkbox"/> Bisexual
<input type="checkbox"/> English	<input type="checkbox"/> Seasonal Worker	<input type="checkbox"/> I do not know
<input type="checkbox"/> Spanish		<input type="checkbox"/> Decline to Specify
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Other (please specify): _____

<input type="checkbox"/> Interpreter Needed	COMPLETE IF PATIENT IS UNDER 18 YEARS OF AGE	
	Mother's Name	
	Father's Name	

RESPONSIBLE PARTY <input type="checkbox"/> Check if same as patient			
FULL NAME			
SSN#	DATE OF BIRTH		
ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	WORK PHONE	
EMAIL ADDRESS	EMPLOYER		

EMERGENCY CONTACT <input type="checkbox"/> Check if same as Responsible Party			
EMERGENCY CONTACT NAME		PHONE #	
Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other: _____			
EMERGENCY CONTACT NAME		PHONE #	
Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other: _____			



PATIENT NAME:	DOB:
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COMMUNICATION AUTHORIZATION

If you are not available, who may we communicate with? (Check all that apply)

I authorize Health Ministries Clinic to share my personal health information with the person(s) below. I understand this authorization is voluntary. I understand that once my information is disclosed, it may be disclosed by the recipient, and the information may not be protected by Federal privacy laws or regulations. I understand this consent will remain in effect until I cancel it in writing.

<input type="checkbox"/> Communicate with Self Only		If you are not available may we leave a voice message?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
NAME:	RELATIONSHIP:	PHONE:	<input type="checkbox"/> Health Info	<input type="checkbox"/> Billing	<input type="checkbox"/> Scheduling <input type="checkbox"/> All
NAME:	RELATIONSHIP:	PHONE:	<input type="checkbox"/> Health Info	<input type="checkbox"/> Billing	<input type="checkbox"/> Scheduling <input type="checkbox"/> All
NAME:	RELATIONSHIP:	PHONE:	<input type="checkbox"/> Health Info	<input type="checkbox"/> Billing	<input type="checkbox"/> Scheduling <input type="checkbox"/> All

HOUSEHOLD INCOME

The following information is used to determine if you may qualify for discounted fees and services. This information can be updated at any time.

Have insurance? You still may qualify for a discount!

Sliding fee scales also apply for possible discounts at the pharmacy, along with medical appointments.

Number in Household	Annual Household Income				
	Slide A	Slide B	Slide C	Slide D	No Slide: (>200% of FPG)
1	<input type="checkbox"/> < \$12,880	<input type="checkbox"/> \$12,881-\$19,319	<input type="checkbox"/> \$19,320-\$22,539	<input type="checkbox"/> \$22,540-\$25,759	<input type="checkbox"/> > \$25,760
2	<input type="checkbox"/> < \$17,420	<input type="checkbox"/> \$17,421-\$26,129	<input type="checkbox"/> \$26,130-\$30,484	<input type="checkbox"/> \$30,485-\$34,839	<input type="checkbox"/> > \$34,840
3	<input type="checkbox"/> < \$21,960	<input type="checkbox"/> \$21,961-\$32,939	<input type="checkbox"/> \$32,940-\$38,429	<input type="checkbox"/> \$38,430-\$43,919	<input type="checkbox"/> > \$43,920
4	<input type="checkbox"/> < \$26,500	<input type="checkbox"/> \$26,501-\$39,749	<input type="checkbox"/> \$39,750-\$46,374	<input type="checkbox"/> \$46,375-\$52,999	<input type="checkbox"/> > \$53,000
5	<input type="checkbox"/> < \$31,040	<input type="checkbox"/> \$31,041-\$46,559	<input type="checkbox"/> \$46,560-\$54,319	<input type="checkbox"/> \$54,320-\$62,079	<input type="checkbox"/> > \$62,080
6	<input type="checkbox"/> < \$35,580	<input type="checkbox"/> \$35,581-\$53,369	<input type="checkbox"/> \$53,370-\$62,264	<input type="checkbox"/> \$62,265-\$71,159	<input type="checkbox"/> > \$80,240
7	<input type="checkbox"/> < \$40,120	<input type="checkbox"/> \$40,121-\$60,179	<input type="checkbox"/> \$60,180-\$70,209	<input type="checkbox"/> \$70,210-\$80,239	<input type="checkbox"/> > \$89,320
8	<input type="checkbox"/> < \$44,660	<input type="checkbox"/> \$44,661-\$66,989	<input type="checkbox"/> \$66,990-\$78,154	<input type="checkbox"/> \$78,155-\$98,399	<input type="checkbox"/> > \$98,400

More than 8 members in household—Please ask the Front Desk for additional information

I DO NOT QUALIFY FOR THE SLIDING FEE SCALE, AND I AM AT OR ABOVE **200%** OF FEDERAL POVERTY GUIDELINES (FPG)

FOR PATIENTS UNDER AGE 18 ONLY

I as the parent/legal guardian of the **minor** aged patient agree to allow the following persons to give consent for the treatment of said minor:

NAME	DOB	RELATIONSHIP TO MINOR
NAME	DOB	RELATIONSHIP TO MINOR
NAME	DOB	RELATIONSHIP TO MINOR

How did you hear about Health Ministries Clinic?

<input type="checkbox"/> Google	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Social Media	<input type="checkbox"/> Flyers
<input type="checkbox"/> Radio Ad	<input type="checkbox"/> Billboard	<input type="checkbox"/> Friend	<input type="checkbox"/> Other



PATIENT NAME:	DOB:
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PATIENT ACKNOWLEDGEMENT—NOTICE OF PRIVACY PRACTICES & PATIENT RIGHTS AND RESPONSIBILITIES

I acknowledge that Health Ministries Clinic (HMC) has given me the right to review and secure a copy of the Notice of Privacy Practices as well as the following documents, which describes how health information about me may be used and disclosed, as well as a complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that HMC reserves the right to change the terms of this notice periodically, and that I may contact Health Ministries Clinic at any time to obtain the most current copy of these documents. I understand that if I have any questions regarding any of these documents, I can contact HMC.

I acknowledge that Health Ministries Clinic (HMC) has given me the right to review and secure a copy of the patient’s rights and responsibilities. I understand that if I have any questions regarding my rights, I can contact Health Ministries Clinic.

A paper copy may be obtained at the front desk

- Payment Agreement
- Insurance Filing/Medicare
- Attendance Agreement
- Notice of Privacy Practice
- Patient Rights and Responsibilities

Health Ministries Clinic (HMC) is committed to providing an inclusive and welcoming environment for all patients and employees. HMC complies with all applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age disability or sex. HMC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

I have answered the information (above) to the best of my knowledge and ability. I have been given the opportunity to review, and I fully understand, and accept, all terms and policies stated above.

_____ Patient/Parent or Guardian Name (PRINT) _____ Patient/Parent or Guardian Signature _____ Date

Patient/Parent or Guardian refuses to Acknowledge Receipt of Privacy Practices:

_____ HMC Staff Name (PRINT) _____ HMC Staff Signature _____ Date

This area is **only to** be filled out by a Health Ministries Staff member, if the above patient needed help filling out this form and the patient and/or legal representative is present.

_____ HMC Staff Name (PRINT) _____ HMC Staff Signature _____ Date