



PATIENT REGISTRATION FORM

FULL NAME

DATE OF BIRTH (MM/DD/YY)

SSN#

GENDER AT BIRTH ☐ Male ☐ Female

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)

LEGAL MARITAL STATUS

☐ Single ☐ Married ☐ Widowed
☐ Divorced ☐ Separated ☐ Partner

EMAIL ADDRESS (REQUIRED FOR PATIENT PORTAL ACCESS)

Employer:

☐ Full time ☐ Part time
☐ PRN

PHARMACY

☐ Health Ministries Clinic Pharmacy ☐ Other Pharmacy (specify): _____

RACE

(Check all that apply)

HOUSING

Are you currently experiencing homelessness?

GENDER IDENTITY*

☐ White ☐ Yes
☐ Black/African American ☐ No
☐ American Indian/Alaska Native **IF YES:** are you utilizing any of the following?
☐ Other Pacific Islander ☐ Transitional
☐ Samoan ☐ Doubling Up
☐ Guamanian or Chamorro ☐ Street
☐ Asian ☐ Other (please specify): _____
☐ Vietnamese **DO YOU LIVE IN PUBLIC HOUSING?**
☐ Filipino ☐ Yes ☐ No
☐ Korean **POPULATIONS**
☐ Japanese (Check all that apply)
☐ Asian Indian ☐ Veteran
☐ Chinese ☐ Farm Worker
☐ Declined to Specify ☐ Migrant Worker
☐ Seasonal Worker

DO YOU IDENTIFY AS
HISPANIC/LATINO?

☐ No
☐ Yes, Mexican, Mexican American, Chicano
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, Other Hispanic Latino

PREFERRED LANGUAGE

☐ English
☐ Spanish
☐ Other: _____
☐ Interpreter Needed

SEXUAL ORIENTATION*

(Not required if under the age of 18)

☐ Male ☐ Female
☐ FTM ☐ MTF
☐ Nonbinary ☐ Decline to specify
☐ Other (please specify): _____
☐ Straight or Heterosexual
☐ Bisexual
☐ Lesbian/Gay/Homosexual
☐ I do not know
☐ Decline to Specify
☐ Other (please specify): _____

*Sexual Orientation and Gender Identity can play a significant role in determining health outcomes. Please see the front desk or ask your healthcare team if you have questions about disclosing this information.

HOW DID YOU HEAR ABOUT HMC?

☐ Social Media ☐ Flyers
☐ Google ☐ Friend
☐ Other: _____

EMERGENCY CONTACT

EMERGENCY CONTACT NAME:

PHONE:

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Child ☐ Other: _____

EMERGENCY CONTACT NAME:

PHONE:

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Child ☐ Other: _____



PATIENT NAME:				DOB:						
INSURANCE INFORMATION (HMC WILL NEED A COPY OF YOUR INSURANCE CARD(S))										
PRIMARY HEALTH INSURANCE:				SECONDARY HEALTH INSURANCE:						
HEALTH INSURANCE COMPANY				HEALTH INSURANCE COMPANY						
NAME OF POLICY HOLDER (IF DIFFERENT FROM ABOVE):				NAME OF POLICY HOLDER (IF DIFFERENT FROM ABOVE):						
GROUP #		POLICY #		GROUP #		POLICY #				
POLICY HOLDER'S DATE OF BIRTH (IF DIFFERENT FROM ABOVE):				POLICY HOLDER'S DATE OF BIRTH (IF DIFFERENT FROM ABOVE):						
POLICY HOLDER'S RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____				POLICY HOLDER'S RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____						
PRIMARY DENTAL INSURANCE										
DENTAL INSURANCE COMPANY										
NAME OF POLICY HOLDER (IF DIFFERENT FROM ABOVE)										
POLICY HOLDER'S DATE OF BIRTH (IF DIFFERENT FROM ABOVE)										
POLICY HOLDER'S RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____										
<input type="checkbox"/> Check if Same as Patient										
RESPONSIBLE PARTY (PERSON RESPONSIBLE FOR PAYING PATIENT ACCOUNT)										
FULL NAME										
SSN#		DATE OF BIRTH								
ADDRESS		CITY		STATE		ZIP CODE				
HOME PHONE		CELL PHONE		WORK PHONE						
EMAIL ADDRESS			EMPLOYER							
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 (PHI) with the third party(s) listed below. I understand this authorization is voluntary. I understand that once my information is disclosed, it may be disclosed by the third party(s), and the information may not be protected by Federal Privacy Laws or Regulations. I understand this consent will remain in effect until I request an update.										
<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



PATIENT NAME:		DOB:			
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.					
<u>Have insurance? You still may qualify for a discount!</u>					
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"/> < \$15,060	<input type="checkbox"/> \$15,601-\$22,590	<input type="checkbox"/> \$22,591-\$26,355	<input type="checkbox"/> \$26,356-\$30,120	<input type="checkbox"/> > \$30,121
2	<input type="checkbox"/> < \$20,440	<input type="checkbox"/> \$20,441-\$30,660	<input type="checkbox"/> \$30,661-\$35,770	<input type="checkbox"/> \$35,771-\$40,880	<input type="checkbox"/> > \$40,881
3	<input type="checkbox"/> < \$25,820	<input type="checkbox"/> \$25,821-\$38,730	<input type="checkbox"/> \$38,731-\$45,185	<input type="checkbox"/> \$45,186-\$51,640	<input type="checkbox"/> > \$51,641
4	<input type="checkbox"/> < \$31,200	<input type="checkbox"/> \$31,201-\$46,800	<input type="checkbox"/> \$46,801-\$54,600	<input type="checkbox"/> \$54,601-\$62,400	<input type="checkbox"/> > \$62,401
5	<input type="checkbox"/> < \$36,580	<input type="checkbox"/> \$36,581-\$54,870	<input type="checkbox"/> \$54,871-\$64,015	<input type="checkbox"/> \$64,016-\$73,160	<input type="checkbox"/> > \$73,161
6	<input type="checkbox"/> < \$41,960	<input type="checkbox"/> \$41,961-\$62,940	<input type="checkbox"/> \$62,941-\$73,430	<input type="checkbox"/> \$73,431-\$83,920	<input type="checkbox"/> > \$83,921
7	<input type="checkbox"/> < \$47,340	<input type="checkbox"/> \$47,341-\$71,010	<input type="checkbox"/> \$71,011-\$82,845	<input type="checkbox"/> \$82,846-\$94,680	<input type="checkbox"/> > \$94,681
8	<input type="checkbox"/> < \$52,720	<input type="checkbox"/> \$52,721-\$79,080	<input type="checkbox"/> \$79,081-\$92,260	<input type="checkbox"/> \$92,261-\$105,440	<input type="checkbox"/> > \$105,441
<input type="checkbox"/> More than 9+ members in household—Please ask the Front Desk for additional information					

<input type="checkbox"/> <u>*I DO NOT QUALIFY FOR THE SLIDING FEE SCALE, AND/OR CHOOSE TO DECLINE*</u>
<input type="checkbox"/> <u>**I ATTEST THAT I AM ABOVE 200% OF FEDERAL POVERTY GUIDELINES (FPG)**</u>

<u>CONSENT FOR TREATMENT OF MINOR</u> <u>FOR PATIENTS UNDER AGE 18 ONLY</u>		
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
<i>**Legal Guardians please bring your paperwork noting your relationship to the minor (if applicable)</i>		
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, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, gender, gender identity, or any other legally protected status.		
HMC OFFICE USE ONLY		
If the above patient needed help filling out this form and the patient and/or legal representative is present		
Staff Name: _____	Staff Signature: _____	Date Completed: _____



PATIENT NAME:	DOB:
PAYMENT AGREEMENT	
<p>I agree all payments and co-payments must be paid at the time of service. I understand to be eligible for the sliding fee scale I must provide proof of income. Proof may consist of my previous tax return, paycheck stubs (3), unemployment printout, etc. This information must be provided at the time of visit for the sliding scale to be offered. I understand if my account is 90 days past due, I will receive a letter stating I have to pay on my account or I am subject for my past due account being written off to bad debt. I understand partial payments will be accepted unless otherwise negotiated.</p>	
INSURANCE FILING	
<p>I hereby authorize Health Ministries Clinic (HMC) to furnish information to insurance carriers concerning my illness and treatments. I understand my insurance will be filed as a courtesy and I agree to be financially responsible for any balance due to Health Ministries Clinic, Inc. I understand failure to provide HMC with current, accurate insurance information will result in all charges becoming my responsibility or responsible party. All co-pays and co-insurance fees are due at time of service. These payments do not guarantee payment in full. Statements will be mailed for charges exceeding the initial payment made. I understand I will be responsible for any charges not paid by my insurance.</p>	
MEDICARE PATIENTS	
<p>Patients with Medicare or Medicaid, please be advised there may be an applicable co-pay for services rendered. I authorize Medicare benefits be made either to me or on my behalf to Health Ministries Clinic, Inc. for any services furnished me by Health Ministries Clinic, Inc. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.</p> <p>I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.</p>	
ATTENDANCE AGREEMENT	
<p>I agree to contact HMC via phone, website or patient portal before the event that I need to cancel or reschedule my appointment. I understand all appointments (i.e., medical, dental and behavioral health) are considered a no-show if I fail to report to the clinic for a scheduled appointment. A no-show will be implemented when a patient shows for their appointment 10 minutes or more after the appointment. I understand I need to arrive 15 minutes before my appointment time, to complete the required check-in process and pay fees at the reception desk. I agree if I have two (2) no-shows within a one-year period, I will be required to meet with a Patient Care Coordinator and/or designee before scheduling another appointment. I understand if I have a third (3) no-show in a one-year period, I may be informed I will no longer have the ability to schedule future appointments or possibly be placed on "same-day scheduling" for a minimum of six (6) months. I understand If I have scheduling privileges suspended, I may request that my status be reviewed by the Chief Executive Officer and/or designee. I acknowledge I understand the expectations about the need to keep my scheduled appointment and the potential consequences if this fails to happen.</p>	
ELECTRONIC HEALTH INFORMATION TECHNOLOGY	
<p>HMC participates in electronic Health Information Technology (HIT). This technology allows a provider or a health plan to make a single request through a Health Information Organization (HIO), to obtain electronic records for a specific patient from other HIT participants for purposes of treatment, payment, or healthcare operations. HIO's are required to use appropriate safeguards to prevent unauthorized uses and disclosures. You have two options with respect to HIT. First, you may permit authorized individuals to access your electronic health information through an HIO. If you choose this option, you do not have to do anything. Second, you may restrict access to all of your information through an HIO (except by law). If you wish to restrict access, you must submit the required information either online at http://www.KanHIT.org or by completing and mailing a form. You cannot restrict access to certain information only; your choice is to permit or restrict access to all of your information. If you have questions regarding HIT or HIO's, please visit http://www.KanHIT.org.</p>	
PATIENT CONSENT FOR SCRIBE AND TELEHEALTH SERVICES	
<p>I understand that HMC provides telehealth services and uses audio scribe services. I give my permission to be audio recorded during my visits, should my provider utilize such services. I acknowledge that my participation is voluntary and that I may revoke this consent at any time providing HMC a 30-day written notice.</p>	
PATIENT ACKNOWLEDGEMENT & NOTICE OF PRIVACY PRACTICES	
<p>I acknowledge that HMC has given me the right to review and secure a copy of the Notice of Privacy Practices, 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. A paper copy may be obtained at the reception desk.</p> <p>I hereby acknowledge that I have read, fully understand, and accept the terms of the financial guidelines and policies stated above.</p>	
PATIENT/PARENT OR GUARDIAN NAME (PRINT):	PATIENT DOB:
PATIENT/PARENT OR GUARDIAN SIGNATURE:	DATE:
<input type="checkbox"/> Patient/ Parent or Guardian refuses to acknowledge Notice of Privacy Practices	

PATIENT'S RIGHTS AND RESPONSIBILITIES

Health Ministries Clinic (HMC) is a community health center that exists to promote and improve the quality of life by providing integrated healthcare. Each patient who entrusts HMC with their care is treated with dignity, respect, and compassion. HMC acknowledges that all patients have fundamental rights and is dedicated to honoring these rights. Every individual should be informed of the patient's rights and responsibilities before being provided care.

PATIENT'S RIGHTS

While patients are in the care of HMC, staff is committed to respecting patient's privacy and their right to be an active partner in making decisions about their health care. Patients have a right to:

1. Be treated with courtesy, dignity, and respect with consideration for personal, cultural, psychosocial, religious, and spiritual preferences regardless of race, color, national origin, age, disability, sexual orientation, gender identity or language preference.
2. Expect communications and records pertaining to their care, including the source of payment, to be kept confidential.
3. Expect any discussions or consultations to be kept private; persons not directly involved in care are not present without patient and/or guardian's permission.
4. Effective communication that considers language needs, as well as hearing, speech and visual impairments.
5. Request information about fee schedules and payment policies.
6. Accurate and honest billing practices.
7. Request a reasonable estimate of the clinical cost of care and/or may receive one prior to treatment.
8. Have complete information about health status, diagnosis, prognosis, and treatment.
9. Receive comprehensive information to make informed treatment decisions.
10. Be respected related to the right to refuse care, treatment, or services in accordance with laws and regulations.
11. Choose a provider that aligns with treatment goals.
12. To have access to, request amendment to, and obtain information on disclosures of patient's health information, in accordance with law and regulation.
13. Express suggestions or grievances to a member of clinic management.
14. Participate in decisions about their health care, unless medically inadvisable.
15. Lawfully assign someone to exercise the rights indicated above on their behalf, if unable to exercise said rights themselves.

PATIENT'S RESPONSIBILITIES

While you are a patient of Health Ministries Clinic patients are expected to:

1. Provide, to the best of their knowledge, accurate information about present complaints, past illnesses, hospitalizations, medications.
2. Report unexpected changes in their health to the nurse or provider.
3. Ask questions to achieve better understanding (treatments, procedures, medications, etc.)
4. Be considerate of other patients and clinic staff.
5. Be a partner in their care.
6. Keep scheduled appointments and/or cancel/reschedule them as early as possible to allow to others a chance to be seen.
7. Inform the health care provider if they feel uncomfortable about a recommended plan of treatment.
8. Provide accurate financial and insurance information needed to determine ability to pay for services.
9. Make reasonable efforts to pay for services at the time of the visit, or according to their payment plan. If this is not possible, notify HMC.
10. Provide the information needed to help with assistive services.
11. Notify HMC about changes regarding their financial situation or health insurance.
12. Respect the rights and property of other patients, staff, and other persons within HMC facilities.
13. Know the regulations and rules that apply while a patient in the clinic.
14. Understand that aggressive behavior (including but not limited to physical assault, verbal harassment, abusive language, sexual language directed at others, threats) can result in dismissal from HMC.

I HAVE READ AND UNDERSTAND THE POLICIES AS STATED AND AGREE TO ABIDE BY THEM.

 Patient Name/Parent/Guardian (Print)

____/____/_____
 Date of Birth

 Signature

____/____/_____
 Date