Promise Community Health Center
Patient Registration

PATIENT INFORMATION

Last Name | **First Name** | **MI** | **DOB** (MM/DD/YY) | **SS#**

Street Address | **City** | **State** | **Zip** | **County**

Is Patient Insured?
Medical ☐ Yes ☐ No
Dental ☐ Yes ☐ No

If Patient under 18:
Mother's Name | **Father's Name**

CONTACT INFORMATION

Primary Phone Number ☐ **Home** ☐ **Cell** ☐ **Work**

Secondary Phone Number ☐ **Home** ☐ **Cell** ☐ **Work**

Promise may contact me for clinical/appointment reminders by the following methods: (check all that apply)

☐ **Text message** (Standard data/messaging rates may apply) ☐ **Email:**

Cell phone carrier: ☐Verizon ☐iWireless/T-Mobile ☐US Cellular ☐AT&T Other:

PATIENT DEMOGRAPHICS

Primary Language Spoken
☐ English ☐ Spanish ☐ Other:__________

Would you like an interpreter?
☐ Yes ☐ No

Race (Check all that apply)
☐ Asian ☐ Black ☐ White ☐ Central American Indian
☐ American Indian/Native Alaskan ☐ Pacific Islander
☐ Native Hawaiian ☐ Other: ____________________

Ethnicity
☐ Hispanic/Latino
☐ Non-Hispanic/Latino

Gender Identity:
Do you think of yourself as:
☐ Male
☐ Female
☐ Transgender (☐ Male-to-Female ☐ Female-to-Male)
☐ Other, please specify:
☐ Prefer not to disclose

Sexual Orientation:
Do you think of yourself as:
☐ Straight or heterosexual
☐ Lesbian, gay, or homosexual
☐ Bisexual
☐ Something else ☐ Don't Know
☐ Prefer not to disclose

Marital Status
☐ Single
☐ Married
☐ Divorced
☐ Widowed

Student
☐ Full-Time
☐ Part-Time
☐ Not a student

Employment Status
☐ Full-Time
☐ Part Time
☐ Not Employed
☐ Retired

Employer | **Zip Code**

Migratory or Seasonal Agricultural Worker? ☐ Yes ☐ No

Military Veteran? ☐ Yes ☐ No

Dental Care: Have you seen a dentist in the last year? ☐ **Yes - Name**:______________________________ ☐ **No**

Medical Care: Do you have a Primary Care Doctor that you see regularly? ☐ **Yes - Name**:______________________________ ☐ **No**

Would you like to learn more about our sliding fee scale program and a possible discount on your bill? ☐ **Yes, Interested**

Gross Household Income (Before Taxes):
$________________ ☐ Monthly ☐ Annually
 # Adults & Children In Household: _________

☐ **Prefer not to disclose income.**
Services not covered by your third-party insurance may be eligible for discount depending on your income level. If you do not wish to disclose your income, you will be responsible for any balance not paid by third party insurance.

GUARANTOR (Person To Be Billed, Check here if same as patient ☐)

Last Name | **First Name** | **MI** | **DOB** (MM/DD/YY) | **SS#**

Street Address | **City** | **State** | **Zip** | **Home Phone** | **Cell Phone**

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

Assignment of Insurance Benefits, Release of Information and Authorization of Treatment.
I the undersigned authorize my insurance benefits to be paid directly to the provider of **Promise Community Health Center** for services render. I understand that I am ultimately financially responsible for any balance due for approved and covered charges not paid by insurance. I hereby authorize Promise CHC to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all my insurance claim submissions. I understand that payment is expected at the time services are rendered. A copy of this is as valid as the original.

Patient/Guardian Signature: ______________________________ **Date:** ______________________________

Relationship to Patient:______________________________

Promise Community Health Center

HIPAA Authorization Form

Promise Community Health Center (PCHC) has taken measures to protect all of our patients' private medical information. PCHC will not release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices.

Your protected health information will be used by PCHC or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. Please review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice and request a copy of the Notice of Privacy Practices for your own records. See the receptionist to receive a copy.

You may request a restriction on the use or disclosure of your protected health information. PCHC may or may not agree to restrict the use or disclosure of your protected health information. If PCHC agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the Federal Privacy Standards. You may revoke this consent to the use and disclosure of your protected health information. You must revoke consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Please see the receptionist with any questions prior to signing this authorization form.

PERSONS AUTHORIZED TO OBTAIN MEDICAL INFORMATION

I give permission to Promise Community Health Center to disclose health and/or billing information to the individuals identified below that are involved in patient care or payment of care. I understand PCHC is not responsible for the information provided as long as it is given to a person listed below.

Note:
If patient is child is below 18, parents do not need to be listed
If patient would like their spouse or partner to have access, the spouse/partner needs to be listed below

Name	Relationship	Phone	DOB
Name	Relationship	Phone	DOB

PATIENT CONSENT AND ACKNOWLEDGEMENT

I have reviewed this consent form & give my permission to PCHC to Use & Disclose my health information in accordance of the Federal Privacy Standards.

I understand that, under HIPAA laws, I have certain rights to privacy regarding my protected 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 more complete description of the uses and disclosures of my health information. I understand that Promise Community Health Center has the right to change its Notice of Privacy Practice from time to time and that I may contact them at any time to receive a current copy.

Family Planning Services Consent: I understand that PCHC provides Family Planning services and that these services are voluntary, confidential (with some limitations), and not required in order to receive other services at Promise.

Patient/Guardian Signature: ____ Date: ___________________

Relationship to patient: __________________________________