Registration Form

Please Print Clearly

Family HEALTHCARE

Date _____

Chart # _____

Last Name:_____ First Name:_____ MI:_____

Other/Maiden/AKA Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Best time to call: _____ **Email address:_____

Birth Month (circle): Jan Feb Mar Apr May June Jul Aug Sep Oct Nov Dec

Birth Day (circle): 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Birth Year: _____ Sex (assigned at birth): ☐ Male ☐ Female ‖ ☐ Transgender

Race: ☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian

☐ Native Hawaiian ☐ Other Pacific Islander ☐ More than one race

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

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

Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

Preferred Pharmacy: _____

Are you a veteran of the United States Armed Forces? ☐ Yes ☐ No

Responsible Party Information

Last Name:_____ First Name:_____ Birth date: _____

Phone number: _____ Relationship to Patient:_____

Address:_____ City:_____ State:_____ Zip:_____

Emergency Contact Information

Last Name:_____ First Name:_____ Birth date: _____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell or Work Phone:_____

Insurance Information

Do you have insurance? ☐ Yes ☐ No

Primary Insurance Company_____

Secondary Insurance Company_____

Consent for Treatment

I authorize any Family Healthcare licensed healthcare provider to perform such diagnostic, medical, counseling, dental, and/or surgical procedures as may be necessary for proper health care. I also give permission for administration of medications and immunizations as may be necessary for treatment or preventive care.

I have read all of the information on this registration form and have completed it to the best of my ability. I certify that this information is true and correct to the best of my knowledge.

I understand that proof of the above information may be required at any time for any reason. If found ineligible, I may be subject to immediate termination of services and/or prosecution for fraud/perjury. I will notify Family Healthcare of any changes in my health status or any of the above information.

_____

Signature (Patient/Legal Representative) Date

Thank you for choosing Family Healthcare!

NOTICE OF PRIVACY PRACTICES

Acknowledgment of Receipt
Effective Date: April 14, 2003

Please review this disclosure carefully.

The Notice of Privacy Practices tells you how Family Healthcare may use or disclose information about you. Not all situations will be described. Family Healthcare is required to inform you of our privacy practices for the information we collect and keep about you.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose your medical information. For each category, we explain what we mean and give you some examples; however, we cannot list every possible use or disclosure. If you have questions about the categories or examples, please contact our Privacy Officer at 435-986-2565.

For Treatment. We use your medical information to understand your health condition and to treat you when you are sick. We share your medical information with the doctors, nurses, technicians, health students, and other personnel who are involved in taking care of you. They may work at our offices, at a hospital, or at another doctor's office, lab, pharmacy, or other healthcare provider to whom we may refer you for tests or treatments.

For example, a doctor outside our clinic who is treating you for a broken leg would need to know if you have other medical problems because these could impact the ability of your body to heal your broken leg. For example, diabetes may slow the healing process for a broken leg so the other doctor would need to know if you have diabetes. We may also disclose your medical information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

For Payment: We use your medical information so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, a state Medicaid agency, or a third party, including the Association for Utah Community Health (AUCH), our 340B administrator (prescription medication program).

For example, we may need to give your health insurance plan information about your office visit so your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

We may submit (or may already have submitted at a past visit) your personally identifiable information to the Utah Medicaid eligibility database and the Children's Health Insurance Program eligibility database to determine if you are enrolled in or eligible for either program.

For Healthcare Operations: We use your medical information to improve the quality of operations at our healthcare practice. For example, we may use your medical records to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine parts of your medical records that do not identify you personally with similar information from other patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, and to compare how we are doing with other healthcare practices.

I have been given a copy of Family Healthcare's Notice of Privacy Practices and have had a chance to ask questions about how my information should be used.

_____

Signature (Patient/Legal Representative) Date

HIPAA Privacy Authorization Form

Disclosure of Health Information

Authorization for Use or Disclosure of Protected Health Information as required by the Health Insurance Portability and Accountability Act.

I hereby authorize Family Healthcare to disclose my protected health information (PHI), both verbally and written, to:

	Name	Relationship	Specific limits to access
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

I authorize the above persons to access the following items in my medical record until I revoke my consent in writing to Family Healthcare.

This release is for the following type of information:

□ All Records □ Prenatal Records □ Medication History □ Billing □ Condition/Treatment
□ Medical Records □ Laboratory & Diagnostic Imaging Results □ Immunizations
□ Other (please specify)_____

Record release for the following documents or verbal communication must be initialed by the patient or guardian:

□ _____ Alcohol/Drug/HIV *Specific limitations* _____
□ _____ HIV/AIDS Diagnosis/Treatment Information *Specific limitations* _____
□ _____ Behavioral Health Treatment Progress / Recommendations / Plans
Specific limitations _____

_____ **I understand that information released may include medical, mental health, and/or drug and alcohol information.** I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it before I revoked it.

_____ I understand that in order to protect the confidentiality of records, I agree to the release of the necessary information and that my permission is limited to the purposes and persons listed above. I understand that I may withdraw/stop this authorization at any time by written request (except for information already disclosed).

_____ I understand that once this facility discloses my health information per this release, it cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state laws governing the use and disclosure of my health information.

_____ I understand that I may withdraw this consent to release information at any time by notifying the agency in writing. I understand that if I do not identify a date or event, then this consent will expire one year from the last date of service to me at Family Healthcare.

_____I have been given a copy of Family Healthcare's Notice of Privacy Practices and have had a chance to ask questions about how my information should be used.

_____

Signature (Patient/Legal Representative) Date

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

By signing below, I authorize Family Healthcare and its affiliated providers to view my external prescription history.

I understand that prescription history from other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff at Family Healthcare, and it may include prescriptions over several years.

I certify that I have read and understand the scope of my consent and that I authorize access to my prescription history.

_____

Signature (Patient/Legal Representative) Date

Thank you for choosing Family Healthcare!

Sliding Fee Discount Program Application

Family Healthcare is committed to "Making Lives Better" in Southwest Utah by providing accessible and affordable healthcare. To continue our current level of discounted services, it is necessary to collect fees from all of our patients when services are received. This includes insurance co-pays or fees based on the sliding scale. When each person pays reduced rates, we can provide services to you and others, when you need us the most. We are able to keep our clinic open. By completing this Sliding Fee Scale form, we can determine potential savings. Even when you have insurance, we recommend you complete this form for services not covered by your insurance or are applied to your annual deductible.

Head of Family Information

Name (Last, First, middle initial)		Date of Birth:	
Address:	City/State/Zip:	Home Phone:	Cell Phone:
Number of people living at home:	Marital status (circle one): Single Married Widowed Divorced Separated		

Family Member Information: Family includes—Self, spouse/partner, and children under age 26.

Name	Date of Birth	Relationship to patient	Age	Employed
1.				Yes/No
2.				Yes/No
3.				Yes/No
4.				Yes/No
5.				Yes/No
6.				Yes/No

Please submit proof of income with your application. Acceptable proof of income includes:

- 2 most recent check stubs
- Alimony letter
- Disability letter
- Unemployment letter
- Social Security letter
- Child Support letter

A. Self-employed—Please, bring your current tax returns including 1099 Schedule C.
B. Not working and living off savings—Bring your most current bank statement.
C. Not working and receiving help from a family member/church—Bring a letter from income source (parent, clergy, agency) stating your situation. The letter must have a signature and date.

To the best of my knowledge, I certify that the above information is true and correct. I agree to inform Family Healthcare of any changes regarding my employment or financial status as soon as the changes happen.

By signing below I give permission to Family Healthcare to enroll me in its sliding fee/discount program. I understand that if I qualify, Family Healthcare may reduce any out-of-pocket cost to me for current medical, counseling, or laboratory/diagnostic testing services. Additionally, dental procedures may be discounted depending on eligibility.

If the above information proves to be incorrect, I understand that the discount provided to me will be terminated and I will be responsible for any current or prior balances. I give permission for Family Healthcare staff to contact my employer or any other appropriate source to verify income.

I understand I will be required to complete a Sliding Fee Discount application every 12 months.

Signature_____ Date_____

Payment is due at time of service.

Sliding Fee Discount For Service

I understand that to be enrolled in Family Healthcare's federal sliding fee discount program, I must complete a Sliding Fee Discount Program Application for all wage earners in my family (self, spouse/partner, children to age 26). I understand that all sources of income, including wages, unemployment, social security, retirement, alimony, child support and disability income will be included. Documented proof of income is required and may include check stubs, letters from employers, statements from person(s) providing your support, copies of income tax information and/or documents from government services.

If I do not provide proof of income now, **I must bring proof of combined family income to Family Healthcare within 7 days or I will be billed the full fees.** I also understand that my eligibility to receive medical care at a reduced rate will be reviewed every 12 months.

I understand that the Sliding Fee Discount Program allows me to receive discounted services. I know that I will pay a co-pay for each visit and may be charged more depending on the services received.

I understand that if I have insurance, Family Healthcare may be able to discount services that are not covered by my insurance policy with proof of income and family size.

Financial Agreement and Release of Information

I authorize Family Healthcare (Southwest Utah Community Health Center) to bill my insurance carrier for services provided by Family Healthcare. I also authorize Family Healthcare to release all or part of my/patient's record to any person or organization liable for payment.

I permit a copy of this authorization to be used in place of the original release of information form and request that the payment of medical insurance benefits be paid to Family Healthcare (Southwest Utah Community Health Center).

I agree to pay for all charges not paid by my insurance company. If my account is sent to a collection agency, I agree to pay all reasonable collection and attorney's fees.

I understand that proof of the above information may be required at any time for any reason. If found ineligible, I may be subject to immediate termination of services and/or prosecution for fraud/perjury. I will notify Family Healthcare of any changes in my health status or any of the above information.

_____

Signature (Patient/Legal Representative) Date

Thank you for choosing Family Healthcare!

Sliding Fee Discount Program Waiver

Proof of income and a declaration of family size (self, spouse/partner, children to age 26) are required to apply for the Sliding Fee Discount Program. By waiving this application, I understand that I will pay full fees for office visits and will not be eligible for financial discounts.

Proof of income is NOT required for any patient whose combined family income is over 200% of the Federal Poverty Level (FPL) guideline or for patients not interested in the Sliding Fee Discount Program.

_____ I have reviewed the current Sliding Scale and declare that my combined family income is over 200% of the FPL. I understand that I and my family do NOT qualify for the Sliding Fee Discount Program.

_____ I am not interested in declaring my personal or combined family income at this time. I am not interested in applying for the Sliding Fee Discount Program.

_____ I understand that I may apply for the Sliding Fee Discount Program at any time in the future or in the event that my income or family size changes.

_____ I have had my questions regarding the Sliding Fee Discount Program answered to my satisfaction.

_____

Signature (Patient/Legal Representative) Date

Thank you for choosing Family Healthcare!

Family HEALTHCARE

Patient's Name: _____Date of Birth: _____ Chart #:_____

If extra space is needed for any question, please continue on the back side of this form.

Purpose of Today's Visit—Please let us know why you are here for an appointment.

1. _____

2. _____

Please list all current medications:

Name: _____Strength: _____ Frequency: _____For: _____
Name: _____Strength: _____ Frequency: _____For: _____
Name: _____Strength: _____ Frequency: _____For: _____
Name: _____Strength: _____ Frequency: _____For: _____
Name: _____Strength: _____ Frequency: _____For: _____

Medical History

Which of the following conditions are YOU currently being treated or have been treated for in the past?

☐ Asthma ☐ Thyroid Problems ☐ Pain (Specify:_____)
☐ Blood Disorder ☐ Hypertension ☐ Heart Problems (Specify: _____)
☐ Cancer ☐ Seizures ☐ Mental Health (Specify:_____)
☐ Diabetes ☐ Stroke ☐ Other (Specify: _____)

Allergies

Do you have any allergies (please check)? ☐ Penicillin ☐ Latex ☐ Other (Specify :_____) ☐ None

Past Surgeries

Surgery: _____ Date: _____ Surgery: _____ Date: _____

Hospitalizations

Date (Mo/Yr.):_____ For: _____ Date (Mo/Yr.):_____ For: _____

Family History

Has any member of your immediate family had any of the following serious illnesses? (Indicate who on the line.)

☐ Asthma _____ ☐ Blood Disorder_____ ☐ Thyroid Problems_____
☐ Stroke_____ ☐ Hypertension_____ ☐ Heart Problems _____
☐ Cancer_____ ☐ Seizures_____ ☐ Mental Health (Specify)_____
☐ Diabetes_____ ☐ Other (Specify)_____

Social and Preventative History:

Do you currently smoke or chew tobacco?	☐ Yes	☐ No	If no, have you in the past?	☐ Yes	☐ No
Are you exposed to smoke in the home?	☐ Yes	☐ No	If no, have you been in the past?	☐ Yes	☐ No
Do you drink alcohol?	☐ Yes	☐ No	If no, have you in the past?	☐ Yes	☐ No
Do you use illegal drugs?	☐ Yes	☐ No	If no, have you in the past?	☐ Yes	☐ No
Have you been exposed to STDs?	☐ Yes	☐ No			
Have you had a pap smear in the last 2 years?	☐ Yes	☐ No	If yes, where? _____		

Learning Needs Assessment:

May we leave detailed messages on your phone? ☐ Yes ☐ No

Do you speak English in your home? ☐ Yes ☐ No If no, what language do you speak? _____

Do you read and write English? ☐ Yes ☐ No

Do you have any cultural or religious practices or beliefs that may affect your care or treatment? ☐ Yes ☐ No

If yes, please specify: _____

How do you like to learn new things? (Check all that apply)

☐ Reading ☐ Discussion ☐ Video ☐ Demonstration / Hands-on ☐ Self-study ☐ Other: _____

Disability Status:

Do you see well? ☐ Yes ☐ No If no, do you use glasses or contacts? ☐ Yes ☐ No

Do you hear well? ☐ Yes ☐ No If no, do you use a hearing device? ☐ Yes ☐ No

Do you have difficulty walking? ☐ Yes ☐ No

Do you have Memory or thinking difficulty? ☐ Yes ☐ No

Do you have Independent Living Difficulty? ☐ Yes ☐ No

Do you have difficulty caring for yourself? ☐ Yes ☐ No

Other disability? ☐ Yes ☐ No Please list _____

Thank you for choosing Family Healthcare!