MRN # _____

PATIENT REGISTRATION FORM

Last Name	First Name	Middle Initial	Preferred Name
Date of birth	**Sex at Birth** □ Male □ Female □ Decline	**Mailing Address** **City** **State** **Zip**	
Home Phone	**Cell Phone**	**What is your marital status?** □ Divorced □ Married □ Single □ Domestic partner □ Separated □ Widowed □ Significant Other	
Social Security Number	**Email Address**	**Preferred Pharmacy**	

RESPONSIBLE PARTY INFORMATION

First/Last Name	Employer	Social Security #
Street address	**City** **State**	**Zip**

Date of birth	Gender □ Male □ Female	Phone Number	Patients Relation to Guarantor

INSURANCE

Insurance company	Employer	
Policy holder's first and last name	**Policy holder's date of birth**	**Policy holder's social security #**

HEALTH CENTER FUNDING INFORMATION

In order to continue the variety of services that we offer here at RCH and to continue to receive grant funding, we are required to collect the following information on every person that visits our facility. This information is reported as a cumulative number and not reported on individual patients.

Employment Status:
□ Employed full time
□ Employed part time
□ Unemployed
□ Retired
□ Disabled

Employer Name:
_____

Employer Address:
_____

What is your household annual income? (Family Annual Income)
□ <$10,000 □$30,000-49,999
□ $10,000-14,999 □$50,000-79,999
□ $15,000-19,999 □$80,000 -99,999
□ $20,000-29,999 □$100,000 +
□ Refuse to disclose

How many people in your family?
(yourself, spouse and minor children under 18 years)
_____
□ Pt declined to participate in slide application process

Referral Source:
□ Billboard
□ Radio
□ Business/Agency
□ Friend or Family
□ Hospital/Clinic
□ Internet Search
□ Social Media
□ Newspaper
□ Fair/Festival/Event

Veteran Status:
□ Veteran
□ Not a veteran
□ Choose not to disclose

Student Status:
□ full time
□ part time
□ Not a Student

Agricultural Status over the last 3 years
□ Migrant □ Seasonal
□ No

Homeless Status:
□ Shelter □ Street
□ Transitional Housing
□ No

Racial Group(s):
□ African American/Black □ Asian
□ Caucasian/White □ Other
□ Native Hawaiian
□ Native American/Alaskan Native
□ Pacific Islander

Ethnicity:
□ Hispanic/Latino/Latina
□ Non-Hispanic/Latino/Latina
□ Choose not to disclose

Do you think of yourself as: **Only if over 12 years of age
□ Lesbian, gay, or homosexual
□ Straight or heterosexual
□ Bisexual □ Something else
□ Don't know □ Chose not to disclose

What is your gender identity? **Only if over 12 years of age
□ Male □ Transgender Female / Male to Female
□ Female □ Transgender Male / Female to Male
□ Other □ Chose not to disclose

What pronouns do you use?
**Only if over 12 years of age
□ he/him/his □ Decline
□ she/her/hers □ Unknown
□ they/them/theirs

Preferred Language:
_____

Do you need an Interpreter?
□ Yes □ No

Emergency Contact Name:	Relation to Patient:	Phone:

_____ _____

(Date) **(Signature of patient) (Or) (Signature of person authorized by law**

MRN # _____

PATIENT REGISTRATION FORM

For your assistance, we have a sliding fee discount program. In order for us to determine if you qualify, please provide us with the following information:

Patient/: _____ **Date of Birth**:_____

Guarantor Name (if different from patient): _____ **Date of Birth**:_____

How many people are supported by this income? Use the number of persons who live in the same household and who share income, food and rent.

Household members: **RCH staff completes**

Name: _____ Date of Birth: _____ Patient: □ Yes □ No MRN_____

Name: _____ Date of Birth: _____ Patient: □ Yes □ No MRN_____

Name: _____ Date of Birth: _____ Patient: □ Yes □ No MRN_____

Name: _____ Date of Birth: _____ Patient: □ Yes □ No MRN_____

Total Household Members: _____

Indicate all source(s) of income for your household. Please check all that apply.

□ Prior Years Taxes □ Wages and Salary □ Unemployment □ Self-employed □ Social Security/SSI

□ Workman's Compensation □ Public Assistance □ Disability □ Support □ Pension Funds

□ VA Benefits □ Alimony/Child Support □ Grants □ other: Specify _____

Reporting No Income

How are you receiving food and shelter?_____

Check all that apply to your current living situation: ☐ In parks/on street/under bridge, ☐ Living in vehicle, ☐ Hotel/motel, ☐ Staying with others—no rent, ☐ Camping/traveling with no income, ☐ other.

*****Self-declared income will apply sliding fee discount for <u>30 days only</u>. To be eligible for future discounted services financial documentation will be required.**

Bottom to be filled out by Rogue Community Health:

Frequency	Type of Income	Income Calculation

Self-Declared: □ Yes □ No

Qualified for Slide: A B C D E

Slide Expiration: _____

Explanation of Benefits: **(**Patient Responsibility for services)

Medical $_____ copay Staff Initials _____

To the best of my knowledge, the information given is true and correct. I give Rogue Community Health permission to verify information about my financial status. I understand this information must be updated annually to determine if my sliding fee scale discount has changed.

Patient/Guarantor Signature:_____ Today's Date:_____

MRN # _____

PATIENT REGISTRATION FORM

AGREEMENT: PLEASE READ CAREFULLY AND SIGN AT THE BOTTOM

Consent for Treatment:
I consent to treatment necessary for the care of the above named patient. I authorize release of all medical records to referring health care providers and to my insurance company, if applicable. I allow fax transmittal and/or HIPAA secure electronic submission of my medical record, if necessary.

Medical Home:
I understand that Rogue Community Health has a model of care called a Patient Centered Medical Home. This means the clinic is my health care setting where either my family or I work in partnership with our care team to address all of our health care needs.
Rogue Community Health is my Medical Home: □ Yes □ No

Financial Responsibility:
All insurance co-pays are due at the time of the visit. All patients with self-pay accounts are asked to bring in payment at each visit. Patients that have made payment arrangements and/or received a monthly statement must make a payment within thirty days of the statement date. If you have payment concerns, please notify the billing department. We will bill your insurance for you; however your account remains your responsibility.

Insurance Authorization:
I understand the financial policy above and accept financial responsibility. By signing below, I assign Rogue Community Health all payments due from my insurance company for services rendered.

Release of Information:
If unable to reach me you may:

Leave a detailed message on my answering machine at home	□ Yes	□ No	□ N/A
Leave a detailed message on my cell phone	□ Yes	□ No	□ N/A
Leave a detailed message at my place of employment	□ Yes	□ No	□ N/A
Discuss my medical condition with members of my household	□ Yes	□ No	□ N/A
Discuss my medical scheduling with members of my household	□ Yes	□ No	□ N/A

If yes, □ anyone □ Specific:_____

Consent to Request Medical Care for Minors:
The following persons are authorized to access medical care for the child named above, for services not related to well-child or preventive services:

Name: _____ Relationship:_____ Phone Number: _____

Name: _____ Relationship:_____ Phone Number:_____

I have read and fully understand the above consent for treatment, financial responsibility, and release of medical information, insurance authorization, and consent to request medical care for minors. These agreements will remain in effect for one calendar year or until revoked by me in writing. If revoked, I understand the authorization will not affect any use or disclosure of information that has already occurred.

Patient OR Guardian Name (please print): _____

Signature of Patient or Guardian: _____

Relation to Patient _____ Patient DOB_____

MRN # _____

PATIENT REGISTRATION FORM

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize Rogue Community Health to **use and disclose** the health and medical information of _____ for the purposes of Treatment, Payment and Health Care Operations.*

* **Treatment** (includes activities performed by a provider, nurse, lab personnel, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any medical personnel who covers our practice by telephone as the on-call medical personnel.

*** Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization).

*** Health Care Operations** (includes the necessary administrative and business functions of our office). Rogue Community Health is part of an organized health care arrangement including participants in the Oregon Community Health Information Network (OCHIN). Your health information may be shared by Rogue Community Health with other OCHIN participants when necessary for health care operations.

You may review Rogue Community Health's **"Notice Of Privacy Practices"** for the additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT. Please verify that you have received a copy of our **Notice** by placing your initials here: _____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the **Notice** may change also. A summary of the **Notice** will be posted in our waiting room and web site indicating the effective date of the **Notice** in the upper right hand corner. We will offer you a copy of the **Notice** on your first visit to us after the effective date of the then current **Notice**. We will also provide you with a copy of the **Notice** upon your request.

As more fully explained in the **Notice**, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. **We are not required to agree to your request**. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other medical personnel who provide call coverage for our office are required to use and disclose your protected health information consistent with the **Notice**.

I understand that I have the right to revoke this CONSENT provided that I do so <u>in writing</u>, except to the extent that Rogue Community Health has already used or disclosed the information in reliance on this CONSENT.

_____ _____ (or)
(Date) (Signature of patient)

_____ _____
(Date) (Signature of person authorized by law)

MRN # _____

PATIENT REGISTRATION FORM

AS A PATIENT, I AGREE TO THE FOLLOWING:

- I agree to treat staff and clients of RCH with dignity and respect.
- I will arrive at specified arrival time for my appointment.
- I will cancel appointments at least 2 hours before appointment time or it will be considered a “No Show”. Repeat “No shows” could result in you losing privileges to schedule future appointments.
- I have been given the opportunity to ask any questions I have about my care through RCH.
- I can request a copy of all authorization documents such as Notice of Privacy Practices (HIPAA), Patient responsibilities, and RCH Responsibilities and Duties.
- I understand that children may not be left in the waiting area while I am being treated
- Payment is due at time of service unless previous arrangement has been made with RCH billing department.

Sign X_____ _____
Patient Signature/Parent/Legal Guardian Signature (Please circle one) Date

Print X_____ _____
Patient/Parent/Legal Guardian Name **(please print)** Date