Heritage Health Center

New Patient Registration & Consent

Patient Demographics

Patient Information: Do you *need help with Forms*? ☐ Y ☐ N | Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Name: (Last) _____ (First) _____ (MI) _____ (Suffix) _____
Minor ☐ Y ☐ N Date of Birth: _____/_____/_____ Social Security # : _____-_____-_____
Sex: ☐ Male ☐ Female **Employer:** _____
Mailing Address: _____ Physical Address: _____ Apt #: _____
City, State, Zip: _____ Home Phone: _____ Cell Phone: _____
Best Form of Contact: ☐ Home Phone ☐ Cell Phone ☐ Other _____ | May we leave a detailed voice message? ☐ Yes ☐ No1
Email: _____ Consent to text: ☐ Y ☐ N Are you interested in signing up for the portal? ☐ Yes ☐ No
If College Student-Permanent Mailing Address: _____
Emergency Contact: (Name) _____ (Phone) _____ (Relationship) _____

Name of Guarantor: _____ Guarantor Date of Birth _____/_____/_____
Mailing Address: _____ Physical Address: _____ Apt: _____ City: _____
State, Zip: _____ Home Phone: _____ Cell Phone: _____ Employer: _____

Insurance Information

☐ Primary Insurance Name: _____Primary Ins. Subscriber Name: _____
Primary Ins. Policy Number: _____ Date of Birth (If not patient) _____/_____/_____ Relationship: _____
Primary Ins. Address, & Phone number: _____
☐ Secondary Insurance Name: _____Secondary Ins. Subscriber Name:_____
Secondary Ins. Policy Number: _____ Date of Birth (If not patient) _____/_____/_____ Relationship: _____
Secondary Ins. Address, & Phone number: _____
☐ Work- Related W/C W/C Case number: _____ Date of Injury _____/_____/_____ Employer: _____
Body Part Injured: _____ State of Injury: _____
☐ Auto Accident or other Liability Insurance: Name of Ins: _____ Date of accident: ___/_____/_____
Claim # _____ Adjuster Name & Phone Number: _____
☐ Self-Pay Did someone talk to you about the Sliding fee program? ☐ Yes ☐ No ☐ Not interested in the sliding fee discount program

** We are requesting the following demographic information to comply with Federal Regulations and to allow us to address our community needs as best as we can, but you may choose to decline answering the following questions. In order to apply for the Sliding Fee Scale Program, this information is required.

Patient Questionnaire

How did you hear us? ☐ Advertising ☐ Patient in practice ☐ Primary Care Physician ☐ Hospital ☐ Backpack Program ☐ Word of mouth ☐ Specialist Physician ☐ Other _____
Preferred Language: ☐ English ☐ Spanish ☐ Russian ☐ Other _____
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other_____
Race: ☐ White ☐ African American ☐ Asian ☐ American Indian ☐ Other _____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separate ☐ Partner ☐ Unknown
Sexual Orientation: ☐ Lesbian, gay or homosexual ☐ Straight/Heterosexual ☐ Bisexual ☐ Other ☐ Don't know ☐ Choose not to disclose
Gender Identity: ☐ Male ☐ Female ☐ Transgender Male/female to male ☐ Transgender female/male to female ☐ Other ☐ Choose not to disclose
Agricultural Worker ☐ Yes ☐ No ☐ Migrant ☐ Seasonal **Are you homeless?** ☐ Yes ☐ No | **Are you a veteran?** ☐ Yes ☐ No
Family Size: _____ Annual Household Income: _____

Staff Use Only: ID # _____ Driver's License Scanned ☐ Y ☐ N Reason not scanned:_____
Primary Insurance card scanned both sides? ☐ Y ☐ N Secondary Insurance card scanned both sides? ☐ Y ☐ N

New Patient Registration & Consent

Patient Acknowledgement & Consent
Treatment Coverage & Communication

Please **initial and sign** to select your current method of coverage and to complete the acknowledgment and consent for Medical Treatment, Notice of Privacy Practices, and Payment Policy.

_____Self-Pay (Patient Visit) & Office Policy on Payment

By signing below, I acknowledge that I have been informed of my responsibility to pay for the professional services or supplies provided to me today by Powell Health Care Coalition, dba Heritage Health Center. It is our policy to collect all co-payments to be made at the time of service.

I , the undersigned client/guardian/guarantor, agree to pay for all services rendered and/or goods sold to me or anyone for whom I am responsible, immediately upon demand. I agree that in the event this agreement is assigned to a third part for collection, I promise to pay an additional collection fee of 35% of the unpaid balance due. I also agree to pay all reasonable attorney fees and court costs that may be incurred.

_____Health Insured Patient Visits

I request that payment of authorized insurance benefits, including Medicare, be made on my behalf for any professional services or supplies provided to me by Powell Health Care Coalition, dba Heritage Health Center.

I acknowledge that I have provided my insurance information today and authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related professional services or supplies by Heritage Health Center to Health Care Financing Administration, my insurance company or other entity upon request to secure payment of my benefits. I understand that I am financially responsible to Heritage Health Center for any charges not covered by health care benefits. It is my responsibility to notify Heritage Health Center of any changes in my health care coverage. In some case exact insurance benefits cannot be determined until the insurance company receives the claim. I understand that I am responsible for the entire bill including any unpaid balance of the professional services or supplies as determined by Heritage Health Center and/or my health care insurer should the submitted claim or any part of the claim be denied for payment or apply to my co-pay, deductible, or coverage limitations.

I , the undersigned client/guardian/guarantor, agree to pay for all services rendered and/or goods sold to me or anyone for whom I am responsible, immediately upon demand. I agree that in the event this agreement is assigned to a third part for collection, I promise to pay an additional collection fee of 35% of the unpaid balance due. I also agree to pay all reasonable attorney fees and court costs that may be incurred.

_____Consent to Treatment

I give consent for medical and behavioral health treatment by the clinical staff of Heritage Health Center. Medical treatment may include questions regarding my past health, current illnesses, medications, and daily habits. It may also include a physical examination and any necessary procedures and tests as determined by my provider. I may cancel this consent for treatment at any time by notifying the clinical staff of the Heritage Health Center in person or in writing. I agree to release my financial information as provided to Heritage Health Center, and to its contracted health providers, as needed to comply with payment review and continued care requirements.

_____Notice of Privacy Practices

By signing this document, I acknowledge review of Heritage Health Notice of Privacy Practices, with a copy available upon request, as required by the Health Insurance Portability and Accountability Act (HIPPA) to ensure that I have been made aware of my privacy rights.

_____I understand and accept Heritage Health Center's Patient/Provider Agreement, with a copy available upon my request.

Signature: _____ Date: _____

Print Patient Name: _____

Staff only: _____

Witness: _____ Date: _____

ID # _____