MedNorth HEALTH CENTER

PATIENT REGISTRATION

Account #: _____ **Processed by:** _____

Insurance Card: Y / N **Date processed :** _____/_____/_____

Please present your insurance card(s) and photo identification to the patient registrar along with this form.

Name: _____ _____ _____
Last First Middle

Date of birth: _____/_____/_____ **Social Security #**: _____ **Sex**: ☐M ☐F **Marital status**: _____
month day year required

Street address: _____

PO Box: _____ **City**: _____ **State**: _____ **Zip code**: _____

Telephone Home/Cell: (____) _____ **Work**: (____) _____ **Email**: _____

Student: ☐Full Time ☐Part Time **School**: _____ **Primary language**: _____

As a Federally Qualified Health Center, MedNorth is required to collect demographic information regarding the patients we serve. The information you provide is confidential. Please check Choose Not to Report if you do not wish to answer a specific question. Thank you for choosing MedNorth as your health care provider.

Race (check one) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ More than one race ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White/Caucasian ☐ *Choose not to report*

Ethnicity (check one) ☐Hispanic/Latino ☐Not Hispanic/Latino ☐ *Choose not to report*

Sexual Orientation:
☐ Straight (not lesbian or gay) ☐ Lesbian or gay ☐ Bisexual ☐ Something Else ☐ 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*

Are you a US Veteran? Yes No

Housing for patient or patient's parent/guardian, if a minor – Please check one

☐ Rent or own home ☐ Transitional ☐ Doubled Up (live with another person or family unit)
☐ Homeless Shelter ☐ Street ☐ Other _____ ☐ *Chose not to disclose*

Annual Family Income (Gross) - Please check one

☐$12,140 or below ☐$12,141 - $16,460 ☐$16,461 - $20,780 ☐$20,781 - $25,100 ☐$25,101 - $29,420 ☐$29,421 - $33,740
☐$33,741 – $38,060 ☐$38,061 - $42,380 ☐$42,381 – $46,700 ☐$46,701 - $51,020 ☐$51,021 - $55,340 ☐$55,341 - over

Family size: _____ ☐ *Choose not to disclose*

Patient's employer: _____ **Address**: _____

Spouse's name: _____ **Date of birth**:_____/_____/_____ **Spouse's Telephone:** (___) _____

Spouse's employer: _____ **Address**: _____

In case of **EMERGENCY**, we may contact: Name: _____ Telephone: (____) _____ Rel: _____

Guarantor Information: (Person who pays the bill?) Name: _____

Telephone: (____)_____Work phone: (____)_____Relationship_____

Address:_____City_____State_____Zip Code_____

Employer:_____Social Security number:_____Date of birth:_____/_____/_____

If Patient is a Minor: (Please complete this section)

Parent/Legal Guardian (1) Full Name: _____ **Telephone**: (_____) _____

Relationship to Patient: _____ **Date of Birth**: _____/____/____ **Work Phone**: (____) _____

Parent/Legal Guardian (2) Full Name: _____ **Telephone**: (_____) _____

Relationship to Patient: _____ **Date of Birth**: _____/____/____ **Work Phone**: (____) _____

***Non-Parent/Legal Guardian Designee** (authorized to accompany minor**) Full Name:** _____ **Rel**: _____

(*IMPORTANT: The information listed above is Not authorization and/or designation of a personal representative. A HIPAA release MUST be signed to discuss ANY information.)

Is this visit due to an Accident/Injury: ☐ Yes ☐ No If yes, date of Injury: _____/_____/_____ ***WC / 3rd party liability form completed:* _____

☐ ***By checking this box, I acknowledge I do not have insurance or have a high deductible plan. I have been offered an application for the slide discount program (Caremed) and DO NOT want to participate.***

I certify that the information given above is true and correct.

_____ ____/_____/_____
(Patient Signature or Parent/Guardian signature, if patient a minor) (Date)

Rev. 02/09/2022

MedNorth Health Center
About Our Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to you personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

It is our policy to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

Patient Acknowledgement of Receipt

I,_____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

_____

Patient's Signature Date

_____

Signature of Parent or Patient's Representative (if applicable) Date

_____

Description of Legal Authority to Act on Behalf of Patient

MedNorth Health Center

Conditions of Examination

Contact Information and Instructions

In order to provide you with quality health services with respect for your privacy, we ask that you instruct us on how to get in touch with you to discuss matters such as important lab results and medical follow up, appointment scheduling, billing issues, pharmacy refill orders or potential drug recalls.

Telephone:

__ OK to leave message with detailed information

__ Leave message with call back number only

Home #: (____)_____

Work #: (____)_____

Cell #: (____)_____

Text #: (____)_____

Written Communication

__ Mail to home address (such as postcards or letters).

__ Mail to work/office

Address: _____

_____

Email: _____

Consent for Examination and Treatment

I give the designated personnel of MedNorth Health Center, my consent for examination, ordering of appropriate lab test(s), diagnostic procedures and prescribing medication and treatment for

_____ Patient's Name

All procedures will be explained to me. I will have a chance to ask questions about advantages, alternatives, and possible adverse effects.

This consent is valid until revoked.

Responsibility for Payment of Bill:

I, the undersigned, understand that I am financially responsible for the services received by the patient and authorize MedNorth to release any medical information required to receive payment for services rendered to the patient.

Beneficiary Agreement:

I request payment of authorized benefits by my insurance carrier be made on my behalf to MedNorth Health Center for services rendered to me by MedNorth Health Center, I understand that this request is valid until revoked by me and that I am responsible for any deductibles and co-insurance of allowable charges not otherwise covered.

Content of Form:

I certify that I have read this form and understand its contents and that the information given by me is true and correct.

Date: _____

Signature: _____

If minor, parent/legal guardian's signature is required.

MedNorth Staff _____

CONSENT TO COMMUNICATE PROTECTED HEALTH INFORMATION TO AN AUTHORIZED PERSON

Patient name (please print):	Date of Birth:

I give permission for MedNorth to VERBALLY share the information I have described below to be released to the persons I have identified below. **This form does not authorize releasing copies of my medical records**.

***I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 & 164 and state confidentiality law governing behavioral health/substance abuse services (GS 122C) cannot be disclosed without my written consent unless otherwise provided or in the regulations. I understand that the information to be released may contain information regarding alcohol abuse, drug abuse, HIV infection, AIDS or AIDS related conditions, psychological, psychiatric or physical limitations.**

I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it. I understand that MedNorth may not condition my treatment based on the signature of this form.

Indicate each person that you approve:

Name: _____Phone: _____

Relationship: ☐ Family ☐ Friend ☐ Caregiver ☐ Other Provider: _____ ☐ Other: _____

This consent expires one year from date executed unless other noted here: ____/_____/_____

Patient signature: _____

Printed name: _____Date: _____

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of (Name of Client) _____ signed by (Enter Name of Person Who Signed Authorization) _____on (Enter Date of Signature) _____ be rescinded, effective _____. I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

Signature of Patient_____Date_____

Signature of Witness _____Date_____