Suncoast Community Health Centers, Inc.

FOR OFFICE USE ONLY Site:_____ Patient Account #: _____

PATIENT REGISTRATION

Please be aware that your name and sex should be reported on this document, in the same way that it is listed with your insurance. This is so that your insurance may be properly billed. If your preferred name or pronouns are different from this, please let us know. Preferred name/pronouns _____

Name: _____

Date of Birth: _____ Social Security #: _____

Home Phone: _____ Cell Phone: _____

Can confidential messages (appointment reminders, etc.) be left on your answering machine or voicemail? ☐ Yes ☐ No

If YES, preferred method of contact: ☐ Home (Voice) ☐ Cell (Voice or Text Messages) ☐ Patient Portal.

E-mail: _____ Would you like access to Patient Portal? ☐ Yes ☐ No

Sex: ☐M ☐F Legal Sex (please check one)

Marital Status: ☐S ☐M ☐D ☐W other: _____ Language Preference: ☐ English ☐ Spanish

Race: ☐White ☐Black/African American ☐Asian ☐American Indian ☐Pacific Islander ☐Other (Specify): _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic

Seasonal Farm Worker: ☐Yes ☐No Migrant Farm Worker: ☐Yes ☐ No

United States Military Veteran: ☐Yes ☐No Homeless: ☐Yes ☐ No

Mailing Address: _____ City _____ ST _____ Zip _____

Street Address: _____ City _____ ST _____ Zip _____

In Case of Emergency Contact: _____

Relationship: _____ HIPAA ☐Yes ☐No Phone #: _____

Street Address: _____ City _____ ST _____ Zip _____

Do you have insurance? ☐Yes ☐No Insurance Name: _____ Policy or Group #: _____

Are you employed? ☐Yes ☐No Employer Name: _____ Are you a student? ☐Yes ☐No

NAME	DATE OF BIRTH	S.S. #	RELATIONSHIP TO PATIENT	EMPLOYED
Head of Household/Responsible Party 1.				
Remaining Household Members 2.				
3.				
4.				
5.				
6.				

FOR OFFICE USE ONLY

Total # of Members Applying for Sliding Fee Discount:	Total Income Verified:
Circle Sources of Income Used: Paystubs Unemployment SSI/SSDI Retirement/Pension Tax Return Alimony Child Support Cash Assistance Other: _____	Frequency: Weekly, Bi-weekly, Monthly, Annually

Qualified Poverty Level	Qualified Medical Slide	Qualified Dental Slide	Qualified Family Planning Slide (Title X)	Slide Effective Date	Slide Termination Date

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By signing below, I acknowledge that the above information is true and correct to the best of my knowledge. Additionally, I understand that the Sliding Fee Discount was calculated based on my household size and income and is only valid for 6 months and will be reviewed at every visit. At the expiration of 6 months, I will need to re-apply and provide new proof of income to continue receiving a discount.

_____ _____

Patient/Responsible Party Signature Date Print Name and Signature of SCHC Employee Date

AUTHORIZATION FOR TREATMENT

____ Initial I authorize the staff of SCHC to provide medical and dental care as needed, including external Rx history. I authorize payment of medical/dental benefits to SCHC from any third party payer. I understand that I am responsible for payment for services rendered to me by SCHC. I understand services cannot be provided to a minor without the presence of a parent/legal guardian, stepparent, grandparent of the minor, an adult brother or sister of the minor, adult aunt or uncle of the minor or a written/verbal authorization from the parent.

PATIENT RESPONSIBILITY AGREEMENT

____ Initial I understand that as a patient I have certain responsibilities to my health care provider. I have been provided a copy of the SCHC Patient Responsibility Agreement, and by signing below, agree to do my part. I understand that if I am uninsured and do not provide proof of income I will be classified as a full fee patient and will not be eligible for a discount. I agree to be responsible for services not covered by my insurance based on Suncoast policies. I understand that if I do not comply with these responsibilities, I may be discharged from care as a patient.

_____ _____

Patient/Legal Guardian Date Witness Date

ADVANCED DIRECTIVES

____ Initial I have been provided information on Advanced Directives.

____ Initial I have an Advanced Directive and have provided a copy for my medical records.

____ Initial I do not have an Advanced Directive.

AUTHORIZATION/CONSENT FOR TREATMENT OF A MINOR

I, _____ hereby authorize _____ to consent to all medical examinations and treatment, and/or dental exam or treatment deemed necessary by SCHC staff for the following minor: _____

(Minor's Name and Date of Birth)

_____ _____

Signature of Parent/Guardian Date

_____ _____

Witness Date

HIPAA

____ Initial I acknowledge that I have been given SCHC's Notice of Privacy Practices.

List of family members or other person, if any, we may inform about your general medical condition, diagnosis, treatment options, and financial responsibility.

Name: _____DOB: _____Phone#: _____Relationship: _____
Street Address: _____ City _____ ST _____ Zip _____

Name: _____DOB: _____Phone#: _____Relationship: _____
Street Address: _____ City _____ ST _____ Zip _____

_____ _____

Patient/Legal Guardian Date Witness Date