SACOPEE VALLEY HEALTH CENTER PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name:	First:	MI:	Nickname:
Social Security Number:	Date of Birth: / /	Sex: ❑ Male ❑ Female	

Mailing Address:		Physical/Local Address: ❑ Same as mailing address	
		Street:	
City:	State:	City:	State:
Zip Code + 4		Zip Code + 4	

Primary Care Provider: ❑ Colleen Shula, FNP ❑ Tiffanie Weston, FNP ❑ Jeffrey Ray, DO ❑ Mayra Brink, PA ❑ Diane Kistler, DO ❑ Other _____

Primary Language Spoken: ❑ English ❑ Other _____

Please enter telephone number and place a √ mark in the box next to the phone # you prefer us to call first.

❑ Home Phone:	❑ Day/Work Phone:	❑ Cell Phone:	Email: _____

EMPLOYMENT INFORMATION

❑ I am employed	Employer:	❑ I am NOT employed	❑ I am retired
Employer Address:			
City:	State:	Zip:	Work Phone:

INSURANCE INFORMATION

Please have the receptionist scan your insurance card.
If your insurance card is not current or available, you will be billed.

❑ I have insurance, listed below	❑ I have NO insurance at this time
Primary Insurance:	Subscriber's Name:
Secondary Insurance:	Subscriber's Name:
Dental Insurance:	**ID Number:**

PERSON RESPONSIBLE FOR PAYMENT		**❑ SELF - If not self, please fill in the spaces below**	
Last Name:	First Name:	Middle Initial:	
Date of Birth: / /	Relationship to Patient: ❑ Spouse ❑ Parent ❑ Other _____		
Mailing Address: (If different than patient)	City:	State:	Zip:
Home Phone Number:	Day/Work Phone Number:		

EMERGENCY CONTACT INFORMATION	**❑ NONE - I have no emergency contact**
Name:	Relationship: ❑ Spouse ❑ Parent ❑ Other _____
Home Phone Number:	Day/Work Phone Number:

IS THERE SOMEONE WHO HELPS YOU WITH YOUR CARE AT HOME? ❑ NO ❑ YES

NAME: RELATIONSHIP: PHONE:

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OTHER REQUIRED INFORMATION

This site is a Federally Qualified Health Center (FQHC) which means we receive a federal grant that allows us to provide a discounted fee program to our patients who qualify. We are required to provide certain information to the Bureau of Primary Health Care each year regarding all of our patients. The *only* reason this information is collected is for reporting purposes and we respect that this is personal and confidential information. Your help is very much appreciated.

Please check off all boxes that apply to you (or the patient that is being seen).

Race	❑ White/Caucasian	❑ Native Hawaiian ❑ Other Pacific Islander	❑ Black/African American	❑ American Indian/ Native Alaskan	❑ Asian ❑ Other _____
Ethnicity	Do you identify yourself as:	❑ Hispanic or Latino	❑ **NOT** Hispanic or Latino		
Check one	❑ Migrant Worker	❑ Seasonal Worker	❑ Homeless	❑ Not Applicable	
Do you need	❑ An Interpreter	❑ Sign Language	❑ Not Applicable		

Military Status: **Are you a Veteran of the U.S. Military** **❑ YES** **❑ NO**

Using the table below, please indicate which column represents your TOTAL family/household income level based on the number of persons included in your household: (Circle one) **W** **X** **Y** **Z**

	W	X	Y	Z
Family Size	Less than or Equal to	Between	Between	Equal to or Greater Than
1	12,060	12,061– 18,090	18,091 – 24,120	24,121
2	16,240	16,241 – 24,360	24,361 – 32,480	32,481
3	20,420	20,421 – 30,630	30,631 – 40,840	40,841
4	24,600	24,601 – 36,900	36,901 – 49,200	49,201
5	28,780	28,781 – 43,170	43,171 – 57,560	57,561
6	32,960	32,961 – 49,440	49,441 – 65,920	65,921
7	37,140	37,141 – 55,710	55,711 – 74,280	74,281
8	41,320	41,321 – 61,980	61,981 – 82,640	82,641

CONSENT FOR TREATMENT AT THE HEALTH CENTER:

1. I am aware that the practice of medicine is not an exact science and that the health center offers no guarantees concerning any treatments or examinations I may have here.
2. I authorize the Health Center and its employees to use the information contained in my record for proper medical purposes, and for clinical improvement audits with information that would be de-identified.
3. I authorize the medical staff of the Health Center to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess, diagnose and treat the condition for which I am seeking care. I understand that it is the responsibility of the provider to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options, and the common risks and anticipated burdens and benefits associated with these options.
4. I understand that the services offered at Sacopee Valley Health Center include medical care, optometry, podiatry, mental health, behavioral health, nutrition, and dental care.
5. I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by the provider.

PAYMENT OF BENEFITS AND INFORMATION RELEASE:

I request that payment of authorized insurance benefits be made on my behalf to the Health Center for any services furnished to me by the Health Center. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable to related services. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered by the Health Center.

NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have received or been offered a copy of Sacopee Valley Health Center's Notice of Privacy Practices.

SIGNATURE:

By signing below, I acknowledge that I have read the above information, that I understand and agree to the above statements, and that I have been afforded the opportunity to have any questions I might have addressed.

_____ _____

Patient/Guardian Signature *Date*