SACOPEE VALLEY HEALTH CENTER PATIENT REGISTRATION FORM

PATIENT INFORMATION			
Last Name:	First:	MI:	Nickname:
Social Security Number:	Date of Birth: / /		Sex Assigned at Birth: ❑ Male ❑ Female
Mailing Address:		Physical/Local Address: ❑ Same as mailing address	
Street:		Street:	
City:	State:	City:	State:
Zip Code		Zip Code	

Primary Care Provider: ❑ Andrea Stemm, PA ❑ Christopher Todd Kitchens, DO ❑ Fredericka Sadovnikoff, PA ❑ Gene Royer, DO ❑ Gregory Griffin, PA ❑ Lori Lenart, FNP ❑ 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	❑ Other:

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 do NOT have insurance at this time	
Primary Insurance:		Secondary Insurance:	
Subscriber's Name:		Subscriber's Name:	
ID Number:		ID Number:	
Dental Insurance:	Subscriber's Name:		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 Number:	Cell Number:	Day/Work Number:	

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

Is there someone you would like to give permission to speak on your behalf regarding your care?
This allows them to obtain appointment, treatment and/or other information pertinent to your health care.
❑ 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 Do you identify yourself as:	❑ Asian Indian ❑ Chinese ❑ Filipino ❑ Japanese	❑ Korean ❑ Vietnamese ❑ Other Asian ❑ Native Hawaiian	❑ Other Pacific Islander ❑ Guamanian or Chamorro ❑ Samoan ❑ Black/African American	❑ American Indian/ Alaskan Native ❑ White ❑ More than One Race ❑ Choose Not to Disclose Race
Ethnicity Do you identify yourself as:	❑ Puerto Rican ❑ Cuban	❑ Mexican, Mexican American, or Chicano/a	❑ Another Hispanic, Latino/a, or Spanish Origin ❑ Not Hispanic, Latino/a, or Spanish Origin ❑ Choose Not to Disclose Ethnicity	
Agricultural Worker Status	❑ Migrant Worker	❑ Seasonal Worker	❑ Not Applicable	
Housing	❑ Not Homeless ❑ Doubling Up	❑ Transitional ❑ Homeless Shelter	❑ Permanent Supportive Housing	❑ Street ❑ Other
Do you need	❑ An Interpreter	❑ ASL Interpreter	❑ Not Applicable	
Gender Identity	❑ Male ❑ Female	❑ Transmasculine (FTM) ❑ Transfeminine (MTF)	❑ Other ❑ Choose not to disclose	
Sexual Orientation	❑ Straight, Heterosexual ❑ Bisexual	❑ Lesbian, Gay, Homosexual ❑ Don't Know	❑ Other: _____ ❑ Choose not to disclose	

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

INCOME INFORMATION

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.

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. This table is based on 2023 FPL guidelines:
(Circle one)

W X Y Z Prefer Not to Disclose

	W	X	Y	Z
Family Size	Less than or Equal to	Between	Between	Equal to or Greater Than
1	$15,650	$15,651 – $23,475	$23,476 – $31,300	$31,301
2	$21,150	$21,151 – $31,725	$31,726 – $42,300	$42,301
3	$26,650	$26,651 – $39,975	$39,976 – $53,300	$53,301
4	$32,150	$32,151 – $48,225	$48,226 – $64,300	$64,301
5	$37,650	$37,651 – $56,475	$56,476 – $75,300	$75,301
6	$43,150	$43,151– $64,725	$64,726 – $86,300	$86,301
7	$48,650	$48,561– $72,975	$72,976 – $97,300	$97,301
8	$54,150	$54,151– $81,225	$81,226 – $108,300	$108,301

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NOTICES AND CONSENTS

CONSENT FOR TREATMENT AT THE HEALTH CENTER:

1. 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.
2. 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.
3. I understand that the services offered at Sacopee Valley Health Center include medical care, podiatry, behavioral health, social services and dental care.
4. 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.

CONFIDENTIALITY AND SECURITY:

SVHC is committed to protecting the confidentiality of patient health information and the health, safety and wellness of patients and staff.

The HIPAA Privacy Rule (45 CFR Part 160) establishes national standards to protect individuals' medical records and other individually identifiable health information (collectively defined as "protected health information" or "PHI") and sets limits and conditions on the uses and disclosures of such information without an individual's authorization. The Rule also gives individuals rights over their protected health information, including rights to examine and obtain a copy of their health records.

SVHC may use secure surveillance cameras in the lobbies and other public areas of the building, as posted for public notification, for the safety and protection of all. SVHC will not videotape or otherwise record patient encounters except with the advance written consent of the patient and only for such dates, times and purposes as the patient may expressly agree. SVHC prohibits the taping by patients of health care encounters with SVHC staff, unless the staff person is notified in advance and consents in writing and the date, time and purpose of the recording can be documented in the patient record. By signing this form, the patient acknowledges that SVHC may withhold healthcare services if a patient requires, or otherwise attempts to videotape or record the delivery of healthcare services by SVHC.

NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have been provided with an opportunity to take a copy of the health center's Notice of Privacy Practices and to ask any questions I have about it.

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*