UNITED COMMUNITY CLINIC

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PATIENT REGISTRATION FORM *(PLEASE PRINT)*

First Name	**Last Name**	**Date of Birth** / /
For Patients Under 18: Name of Parent/Legal Guardian		**Social Security Number:** - -
Address: **City** **State** **Zip Code**		**Gender assigned at Birth:** ☐Male ☐Female **Gender:** ☐Male ☐Female ☐Other Transgender: ☐MF ☐FM ☐Choose not to disclose **Sexual Orientation: (optional)** ☐Straight/Heterosexual ☐Lesbian ☐Gay ☐ Bisexual ☐Don't know/something else ☐Choose not to disclose
Home Phone: ( )	**Cell:** ( )	
Work/Other Phone: ( )	**E-mail:**	
Preferred Contact *(check one)* ☐ Home ☐ Cell ☐ E-mail ☐ Text	**OK to identify as SCHC?** ☐Y ☐N	
Emergency Contact Name:	**Relationship:**	**Emergency Phone:**

ETHNICITY:
☐ Hispanic
☐ Non-Hispanic
☐ Unknown

RACE:
☐ Alaskan Native
☐ American Indian
☐ Asian
☐ Black/African-American
☐ Hawaiian Native
☐ Middle Eastern
☐ Multi-Racial
☐ Pacific Islander
☐ White
☐ Declined
☐ Unknown

PRIMARY LANGUAGE:
☐ English ☐ Cantonese
☐ Spanish ☐ Mandarin
☐ Other: _____
Interpreter Needed? ☐ Yes ☐ No

LIVING SITUATION/HOUSING: (optional)
☐ Own home
☐ Rent
☐ Permanently live with friend/relative
☐ Temporarily live with friend/relative
☐ Hotel/Motel
☐ Public housing
☐ Homeless *(please select)*
☐ Transitional housing
☐ Shelter
☐ Rescue mission
☐ Street
☐ Doubling up
☐ Other/Unknown
☐ Choose not to disclose

EMPLOYMENT: (optional)
☐ Employed Full-Time
☐ Employed Part-Time
☐ Self Employed
☐ Unemployed
☐ Student
☐ Retired
☐ Child
☐ Other/Unknown

CITIZENSHIP: (optional)
☐ US Citizen
☐ Legal resident
☐ Visitor
☐ Other: _____

FARMWORKER: (optional)
☐ Migrant ☐ Seasonal
☐ Neither

VETERAN STATUS: (optional)
☐ Yes ☐ No

MARITAL STATUS:
☐ Married ☐ Single
☐ Divorced ☐ Domestic Partner
☐ Separated ☐ Other: _____
☐ Widowed ☐ Declined/Refused

EDUCATION: (optional)
☐ Completed grade _____
☐ Completed high school
☐ Some college
☐ Completed college
☐ Post graduate degree

Do you have a disability or impairment? ☐ Yes ☐ No
Type: ☐ Mobility ☐ Visual ☐ Hearing ☐ Learning
☐ Mental/Behavioral ☐ Other: _____

Do you use drugs or alcohol in a way that hurts your health and/or causes problems in your life? ☐ Yes ☐ No

DO YOU HAVE HEALTH INSURANCE OR MEDI-CAL? ☐ Yes, Medi-Cal ☐ Yes, Other Insurance ☐ No

Name of insurance company: _____ Policy number: _____

NUMBER IN HOUSEHOLD: _____ **MONTHLY INCOME: (optional)** _____

Do you have a preferred pharmacy? ☐ Yes ☐ No **Name:** _____
Location: _____ Phone _____

Reason for Visit Today: _____

SIGNATURE: _____ **DATE:** _____

Patient's Name (Please Print) **DOB (Date of Birth)**

MEDICAL TREATMENT AUTHORIZATION AND CONSENT FORM

This section is designed for those situations where minors are unaccompanied by either parents or legal guardians. This gives authority to a designated adult to arrange for medical care which cannot be provided to a minor without approval by the parent(s) or legal guardian(s) unless there is written consent authorizing an agent to give approval.

THE FOLLOWING INDIVIDUAL(S) ARE AUTHORIZED TO BE INVOLVED IN MY CHILD'S MEDICAL TREATMENT INCLUDING BRINGING HIM/HER IN FOR OFFICE VISITS AND TO MAKE ANY NECESSARY MEDICAL DECISIONS:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

INSURED PERSON (IF NOT PATIENT)

CANCELLATION & NO-SHOW POLICY: We require 24 hours' notice in the event of a cancellation. The charge for cancellation without proper notice is $40 for medical visits. This charge will not be covered by insurance but will have to be paid by you personally prior to receiving additional treatment. **Patients Initial: _____**

FINANCIAL POLICY: We bill your personal insurance carrier solely as courtesy to you. You are responsible for your bill. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due In full from you. If your insurance company request a refund of payment made to us, you may be responsible for money refunded to your insurance company. If any payment is made directly to you by the Insurance company for services billed by us. You recognize an obligation to promptly remit the payment to us. If formal collection procedures become necessary, you will be responsible for additional costs Incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no lability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you, and you agree to pay your portion of this bill.

ATTENTION

PATIENTS WITH PRIVATE/COMMERCIAL INSURANCE
PLEASE BE AWARE THAT IT IS YOUR FINANCIAL OBLIGATION AND RESPONSIBILITY TO PAY FOR THE FOLLOWING FEES

- ➔ **CO-INSURANCE**
- ➔ **COPAYMENTS**
- ➔ **DEDUCTIBLES**
- ➔ **IN NETWORK/ OUT OF NETWORK COVERAGE**
- ➔ **PERCENTAGE COVERAGE**

FOR FURTHER QUESTIONS PLEASE CALL YOUR INSURANCE OR BROKER FOR FURTHER QUESTIONS.

INFORMATION AND ASSIGMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I certify that the information I have reported with regard to my insurance coverage is correct.

Signature **Date**

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HIPAA

Patient's Name (Please Print) _____ **DOB (Date of Birth)** _____

_____ *Initials* ***Acknowledgement of receipt of Notice of Privacy Practice regarding protected health Information:***

I have received the Practice' s Notice of Privacy. Photocopies of this document are to be as valid as the original.

_____ *Initials* ***Assignment of Benefits:***

I acknowledge financial responsibility for all facility and physician fees. I understand that the physician billing office will file my insurance claim and I assign direct payment to the physician all payments made under the terms and provisions of my policy. I further understand that any disputes on coverage are between my insurance carrier and myself and I will be responsible for payment for denied services regardless of the outcome of my dispute. I acknowledge financial responsibility for all charges if inaccurate insurance information is given at the time of service arid the information is not corrected prior to my insurance company's timely filing limit.

_____ *Initials* ***Communication Preferences Regarding PHI***

To assist in your care, it may be necessary to release our Protected Health Information to someone other than yourself. To whom may we talk? Please check boxes and write in name(s).

Yes	***No***	
___	___	Spouse/Significant other: _____
___	___	Parent/ Step -Parent : _____
___	___	Child/ Grandchild: _____
___	___	Other Person(s): _____
___	___	Caregiver: _____

_____ *Initials* ***May we leave a message on: _____Home _____Cell _____Work***

_____ _____

Patient/ Representative Signature ***Date***