HOPE & ESPERANZA
COMMUNITY HEALTH CENTER

# *Patient Registration Form*

## Patient Information

| Last Name | First Name | Middle | Home Phone | Primary Contact |
|---|---|---|---|---|
| | | | Cell Phone | ☐ Home ☐ Cell ☐ Work |
| DOB / / | SSN# | Country Of Birth | Work Phone | |
| Mailing Address | | Apt# | Ok to leave voice message: ☐ Yes ☐ No<br>Ok to leave a text message: ☐ Yes ☐ No<br>*MSG & data rates may apply | |
| City | State | Zip | Best time to reach you: ☐ AM ☐PM<br>Opt out of all Practice Communication ☐ | |
| Home Address (If Different from Mailing) | | | Email Address | |
| City | State | Zip | Preferred Language | Interpreter Needed? ☐ Yes ☐ No |

## Emergency Contact

| Emergency Contact Full Name | Relationship |
|---|---|
| Address | Phone Number |

**We are requesting the following information of all patients in order to understand our patient needs better, to help our staff use the most respectful language when addressing you, and for funding purposes that may help reduce the cost of your healthcare.**

**Gender at Birth**
☐Female ☐Male

Preferred Gender

**Marital Status**:
☐Single ☐Married
☐Widowed ☐Divorced
☐Separated ☐Partner

**Ethnicity**- Check one
☐ Hispanic
☐ Non-Hispanic
☐ Unreported/Refused

**Housing Status**
☐ Own – Private
☐ Rent – Private
☐ Rent – Public Housing (Section 8, NYCHA)
☐Senior Housing
☐ Homeless Shelter
☐ Street
☐ Transitional
☐ Doubling up

**Gender Identity**: Check as many as apply
☐Male
☐Female
☐Female-to-Male/Transgender
☐Male-to-Female/Transgender
☐Gender queer, neither exclusive male nor female
☐ Choose not to disclose

**Sexual Orientation** – Check one
☐Straight/ Heterosexual
☐Lesbian/Gay/Homosexual
☐Bisexual
☐Do Not Know
☐Choose Not to Disclose
☐Something else, please describe: _____

**Employment Status**:
☐Full Time
☐Part Time
☐Retired
☐Active Military
☐Reserved Military
☐Self Employed
☐Not Employed

Employer Name:

**Student**:
☐ Full Time
☐ Part Time
☐Not a Student

**Race** – Check as many as apply
☐ White
☐ Asian
☐ Black/African American
☐ Native Hawaiian
☐ American Indian
☐ Pacific Islander
☐ Alaskan Native
☐ Other
☐ Unreported/Refused

**Are you a**:
Veteran ☐ Yes ☐ No
Board Member ☐ Yes ☐ No
LIFQHC employee ☐ Yes ☐ No

**How did you hear about us? (Please check one)**
☐ Employee
☐ Patient/Friend
☐ Newspaper
☐ Flyer/Poster/Brochure
☐ Referral
☐Insurance Company
☐Facebook/Social Media
☐Other: _____



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| Parent/Guardian Information – Please complete if patient is under 18 years of Age | | | | Responsible Party |
|---|---|---|---|---|
| Mother's Name | DOB / / | Phone | Address | ☐ |
| Father's Name | DOB / / | Phone | Address | ☐ |
| Guardian's Name | DOB / / | Phone | Address | ☐ |

| Insurance Information: | | |
|---|---|---|
| Primary Insurance Name | | Policy # |
| Name of the Insured ☐ Same as Patient | | DOB of Insurance Holder / / |
| Patient's Relationship to the Insured<br>☐ Self ☐ Spouse ☐ Child ☐ Other: | Primary Care Provider on Insurance Card | |
| Secondary Insurance Name: | | Policy # |

| Pharmacy Information | | |
|---|---|---|
| Pharmacy Name | Phone | Address |

| Primary Care Provider | | |
|---|---|---|
| PCP Name | Phone | Address |
| **Advanced Directive:** ☐ **Yes** ☐ **No** ☐ **I Decline** | | **Living Will:** ☐ **Yes** ☐ **No** |

| Other Healthcare Providers: | | |
|---|---|---|
| Name | Phone:<br>Fax: | Specialty |
| Name | Phone:<br>Fax: | Specialty |
| Name | Phone:<br>Fax: | Specialty |

I agree to allow Ironbound Community Health Center to contact me regarding my private health information, evaluation, and

_____ _____

Signature of Patient or Representative Date

I verify that the information above is correct to the best of my knowledge.

_____ _____

Signature of Patient or Representative Date



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# HIPAA ACKNOWLEDGEMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Pratices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name _____

Signature _____

Signature Date _____

Relationship to Patient (if patient unable to sign) _____

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# Consent Form

**Consent to Treatment**: I authorize Ironbound Community Health Center Inc. (ICHC) and its medical, nursing and other professional staff members, to provide such health care services and administer such diagnostic and therapeutic procedures and treatments as, in the judgment of ICHC's medical personnel, is deemed necessary or advisable in my care. This includes all routine diagnostic tests and procedures, including diagnostic x-rays, the administration and/or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examination. I understand that no guarantees have been made to me as to the results or effectiveness of treatments or examinations performed by ICHC personnel. HIV testing is now a part of routine care and written consent is no longer required. I do have a right to decline HIV testing at any time. The ICHC offers family planning services. I understand that my acceptance of family planning services is not a prerequisite to eligibility for, or receipt of, any other services that is offered by the ICHC.

**Release of Information**: I authorize ICHC to use and disclose my health information for the following purposes: (1) to provide for, arrange or coordinate my health care treatment; (2) to enable ICHC to obtain payment for the services it provides to me; and (3) to permit ICHC to carry out ordinary health care and business operations such as quality assurance, service planning and general administration.
I am aware that this authorization to use and disclose information may include information regarding:

- HIV or AIDS
- Alcohol or drug abuse
- Mental illness or any mental health condition
- Sexually transmitted diseases
- Family planning, pregnancy and abortion
- Genetic tests or genetic disease

I am aware that ICHC may share information with my other medical providers for medical treatment or with a third party for financial payment through electronic means.

**Assignment of Benefits**: I assign to ICHC all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers and other third parties who are financially liable for the medical care and treatment provided by ICHC

**Financial Obligations**: I agree, that, except as may be limited by law or ICHC's agreements with third party payers, in the event of non-payment by a third party for which I have provided an assignment of benefits, I am obligated to pay all amounts due for services provided at ICHC facilities in accordance with the rates and terms of ICHC in effect on the date of service. I also agree that I am responsible for any applicable copayments, coinsurance or deductibles.

**No- Show Policy – Important Notice**:
Please remember to be courteous to us and other patients by calling **at least 4 hours prior** to your appointment time to cancel if you cannot make it. This will allow us to serve our patients better.

**I certify that I have read this form and that I am the patient or I am duly authorized by the patient as the patient's representative to execute this form and accept its terms.**

Signature of Patient or Representative: _____ Date: _____

Nature of Relationship to Patient (if patient not signing): _____

**Reports to NJS Immunization Information System**: I hereby authorize ICHC to report any immunizations that its medical staff administers to me to the New Jersey State Immunization Information System.

Signature of Patient or Representative: _____ Date: _____

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# Eligibility Determination for Sliding Fee Discounts

It is Ironbound Community Health Center, Inc. (ICHC) policy to provide essential services to all patients regardless of the patients ability to pay. Discounts are set by the ICHC consumer Board of Directors and are offered based on the information you provide regarding your family size and income. If you are eligible for a sliding fee discount, it will apply to all services received at ICHC, but not for those services provided outside the Health Center.

**Please complete the following information, even if you have insurance.**

***Household Income Before Taxes***

| **HOUSEHOLD MEMBER** | **MONTHLY INCOME** | **YEARLY INCOME** |
|---|---|---|
| Self<br>Name: | | |
| Spouse<br><br>Dependent Children | | |
| Other dependents<br><br>**Total** | | |

☐ I am declining to provide information on my income and family size and agree to pay the full ICHC fee.

**ACCEPTABLE PROOF OF INCOME IS REQUIRED FOR THE SLIDING FEE DISCOUNT PROGRAM. IF YOUR FINANCIAL SITUATION CHANGES, PLEASE KEEP ICHC INFORMED.**

☐ I certify that all information shown above is true, accurate and correct. I understand that if ICHC determines that I misrepresented or falsified information, I will no longer receive discounts and may be asked to pay back discounts provided.

☐ I agree to provide documentation of my income at my next visit.

Name (print)_____ Signature: _____

Witness:_____ Date: _____

Staff to complete information below

| | | | |
|---|---|---|---|
| 1. Eligible for Sliding Fee Discount: | Yes | No | Patient Refused |
| 2. If yes, acceptable proof of income provided: | Yes | No | Patient Refused |
| 3. If insured, Health insurance card provided: | Yes | No | Not applicable _____ |
| 4. Patient reports no income | Yes | | |
| 5. Patient is unable to obtain proof from an employer (This includes paid in cash/off the books earnings) | Yes | | |

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## Financial Policy

Thank you for choosing Ironbound Community Health Center, Inc. (ICHC) as your healthcare provider. We are committed to developing and maintaining supportive relationships with you and your family and we want your patient experience to be a good one. Payment for the services you receive at ICHC is an important part of sustaining that relationship. Our financial policy helps to make sure that we can provide quality care to all of our patients.

1. Payment owed for services received at ICHC is due at the time of service. If a patient fails to make a payment at the time of service, ICHC will bill the patient and expect timely payment to be made.
2. ICHC will offer a sliding fee discount program and apply a discount to the amount owed for services for eligible patients. Eligibility for discounts is based on income and family size. All ICHC patients may be assessed for eligibility for the sliding fee discount program.
3. ICHC has staff available to help patients understand the sliding fee discount program, review eligibility for discounts, and assist in setting up a payment plan for amounts owed to ICHC.
4. Please be advised all lab work is sent out for processing and, therefore, billed by the lab. If you have any questions regarding an invoice received for these services please contact our office immediately.

## Insurance Policy Notice

If you have insurance, ICHC will file claims with your insurance company for the services you receive. It is important that your insurance information is complete and current, and that you provide any updates to ICHC staff. Patients may be held financially responsible for all charges, whether covered and/or paid by insurance

Patient Name:_____

Patient Signature:_____

Date:_____