MARIN CITY Health & Wellness Center

PATIENT REGISTRATION FORM

DATE:

Name First: _____ **Last:** _____ **Suffix:** _____

Other Name (s) Used: _____ **Sex: Male** ☐ **Female** ☐ **Transgender** ☐

Mailing Address: _____ **City** _____ **State** _____ **Zip** _____

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

Separated ☐ **Partner** ☐

Phone (Home) (_____**)**_____ **(Cell)(** _____**)**_____ **May we leave a message? Brief** ☐ **Extended** ☐

Date of Birth: _____/_____/_____ **SS#** _____-_____-_____

Email: _____ **Pharmacy:** _____

Emergency Contact: _____ **Phone** _____ **Relationship**_____

Responsible Party (If patient is a minor complete this section)

Name First:_____ **Last:** _____ **Relationship**_____

Address (If different) _____ **City** _____ **State** _____ **Zip** _____

Date of Birth: _____/_____/_____ **SS#** _____-_____-_____

By answering the following questions, you will give us information we need to acquire grant funds to help uninsured and underinsured residents in our community. This information also helps us recognize patients who qualify for specially funded programs or services. This information will be part of your confidential medical record.

	YES	NO
Is your name on a signed lease agreement?		
Do you live with a relative, friend, or significant other?		
Are you doubling up?		
Are you homeless?		

	YES	NO
Live in temporary housing?		
Live in a shelter?		
Live in Public Housing?		

Insurance Information:

Employed: Yes No If yes, Full Time Part Time

Employer: _____

Employer Address: _____

Student: Yes No If yes, Full Time Part Time

Primary Insurance: _____

Insured Name: _____

Insured ID #:_____

Patient Relationship to Insured:

Self Spouse Child Other

Number of people in patient's household: _____

Monthly household gross income: $_____

What type of work does the patient do? (Circle one)

Professional Clerical Sales Service Laborer Other Agriculture If Agricultural, employed year around Migrant Seasonal

Patient's Primary Language: _____

Ethnicity: Hispanic Non-Hispanic

Race:

African American/Black American Indian Alaskan Native Asian Caucasian/White Pacific Islander

Other :_____

PAYMENT POLICY: Regarding ***Medi-Cal and/or Medicare*** please provide us with your current card at each visit. If you have a share of cost, you will be asked to pay that amount at the time of service. ***Private insurance*** please provide us with a copy of your insurance card at each visit, all co-pays and deductibles are due at the time of service. ***Private Pay*** patients full amount us due at the time of service. We accept CASH, CHECKS, and CREDIT CARDS. We offer a Sliding Fee discount if you qualify. Please ask a receptionist for additional information. All sliding fee program co-pays are expected at the time of service. We offer different ***government funded*** programs in which you may qualify. If you would like more information please ask our receptionist. We depend on your prompt payment for services so that we can continue to provide quality, low-cost care for our community. Thank you for choosing us as your health care provider.
_____ **(Initials)**

CONSENT: In order to provide treatment, bill your insurance, or release information required by your insurance carrier, we must receive your consent by initializing the areas indicated and by providing your signature below.

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT: I authorize payment of medical benefits to Marin City Health and Wellness Center (MCHWC) for professional services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney fees. _____ **(Initials)**

RELEASE OF INFORMATION: I authorize release of all information necessary to secure the payment of benefits related to my care. I further agree that a photocopy of this agreement shall be as valid as the original._____ **(Initials)**

CONSENT OF TREATMENT: I hereby authorize and consent to procedures necessary for diagnosis and treatment for myself and my family while a patient at MCHWC. _____ **(Initials)**

Your signature below indicates you have read, understand, and agree to the payment policy and consents. This agreement will remain in effect until revoked by the patient in writing.

Patient Signature _____ Print Name _____ Date_____

NOTICE OF PRIVACY PRACTICES: Marin City Health and Wellness Center is committed to protecting your personal health information in compliance with the law. The Notice of Privacy States: (A copy will be given upon request)

- Our obligations under the law with respect to your personal health information
- How we may use and disclose the health information that we keep about you
- Your rights relating to your personal health information
- Our rights to change our Notice of Privacy Practices
- How to file a complaint if you believe your privacy rights have been violated
- The conditions that apply to uses and disclosures not described in this Notice
- The person to contact for further information about our privacy practices.

I hereby acknowledge that I have received/been offered a copy of the Notice of Privacy Practices.

Patient Signature _____ Parent (If Minor)_____ Date_____

MEDICARE SIGNATURE ON FILE: I request that payment of authorized Medicare benefits be made on my behalf to MCHWC for any services furnished to me by the listed provider/supplier. I authorize any holder of medical information about me to release to the health care financial administration and its agents any information needed to determine these benefits payable to related services. I understand my signature below requests that payments be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated or the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determined by the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature _____ Print Name _____ Date_____