Shawnee Health Service

Patient Registration Form

Welcome to Shawnee Health Care - Your Health Home! To register, please complete this form. Several of the items below help us ensure that we are meeting the needs of the population we serve. Let us know if you have any questions or if you need help completing this form.

1. Patient Information:

Legal Name: (Last, First, Middle) _____

Preferred Name:_____ Social Security Number:_____

Date of Birth:_____/_____/_____ Legal Sex: Male Female

Shawnee Health Care will send you mail to this address. We believe it's important to communicate with you, and at times, we do mail information.

Home Street Address:_____

City:_____ State:_____ Zip Code:_____

May our automated system call you about your appointments? Yes No

Consent to Call? Yes No Consent to Text? Yes No

Home Phone:_____ Mobile Phone: _____

Would you like access to your lab results, medication refills, appointments, billing and secure messaging? If yes, provide your email below and we will invite you to our patient portal.

Email address:_____

Select your preferred method of communication: Home Phone Mobile Phone Patient Portal

What is your preferred pharmacy/location?_____

What is your preferred lab? _____

2. Select the options that best apply:

Relationship Status: Married Single Divorced Separated Widowed Partner

Do you see any other providers? (include any primary care provider, dentist, psychiatrists, or specialists):

Primary Language: English Spanish Mandarin Quiche Arabic Korean Other:_____

Race: Asian Native Hawaiian Other Pacific Islander Black/African American American Indian/ Alaska Native White

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Do you need a language interpreter? Yes No Do you need a sign language interpreter? Yes No

What is this information for? Shawnee Health Care receives money from the federal government to help provide health care services based on the information below. By providing this information, you help us continue to receive this money and provide quality health care services. Personal financial information is not released. We appreciate your help!

Family Size 1	0 – 13,590.00	13,590.01 - 16,987.50	16,987.51 - 20,385.00	20,385.01 - 23,782.50	23,782.51 - 27,180.00
	27,180.01 & above				
Family Size 2	0 - 18,310.00	18,310.01 - 22,887.50	22,887.51 - 27,465.00	27,465.01 - 32,042.50	32,042.51 - 36,620.00
	36,620.01 & above				
Family Size 3	$0 -23,030.00	23,030.01 - 28,787.50	28,787.51 - 34,545.00	34,545.01 - 40,302.50	40,302.51 - 46,060.00
	46,060.01 & above				
Family Size 4	$0 - 27,750.00	27,750.01 - 34,687.50	34,687.51 - 41,625.00	41,625.01 - 48,562.50	48,562.51 - 55,500.00
	55,500.01 & above				
Family Size 5	$0 - 32,470.00	32,470.01 - 40,587.50	40,587.51 - 48,705.00	48,705.01 - 56,822.50	$56,822.51 - 64,940.00
	64,940.00 & above				
Family Size 6	$0 - 37,190.00	37,190.01 - 46,487.50	46,487.51 - 55,785.00	55,785.01 - 65,082.50	65,082.51 - 74,380.00
	74,380.01 & above				
Family Size 7	$0 - 41,910.00	41,910.01 - 52,387.50	52,387.51 - 62,865.00	62,865.01 - 73,342.50	73,342.51 - 83,820.00
	83,820.01 & above				
Family Size 8	$0 - 46,630.00	46,630.01 - 58,287.50	58,287.51 - 69,945.00	69,945.01 - 81,602.50	81,602.51 - 93,260.00
	$93,260.01 & above				

Family Size over 8? Add $4,720.00 for each additional person

Farm work includes: Orchards, vineyards, flowers, vegetables, trees, herbs, berries, dairy, poultry, pigs, and bees as well as the preparation and processing for market or delivery to storage.

Are you or is anyone in your family working on a farm? Yes (move to next question) No (skip next 2 questions)

In the past 2 years have you or a family member moved in order to do farm work? Yes No

In the past 2 years have you or a family member done farm work on a seasonal basis? Yes No

What is your housing situation today?

I have housing I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, in a car, or in a park)

Are you worried about losing your housing? Yes No I choose not to answer this question

Are you a veteran? Yes No Are you a coal miner? Yes No

What are these questions used for? The following questions help us provide services to the community and to better understand the needs of the populations we serve.

How do you identify your sexual orientation?

Gay/Lesbian Straight Bisexual Something Else Don't Know Prefer Not to Say

Which gender do you identify as? Male Female Trans Man (Female-to-Male) Trans Female (Male-to-Female)

Other:_____ Prefer Not to Say

The following questions are optional. We use these questions to connect patients with community resources or services. Circle all that apply.

In the past year, have you or any of your family members had difficulty or have been unable to get the following?

Food Clothing Utilities Child Care Transportation Medicine/Health Care (medical, dental, vision or mental health)

Have you recently been to the emergency room? Yes No

Have you recently been in jail, correctional facility or detention center? Yes No

We have staff that can assist you with your needs. would you like to speak with someone? Yes No

How did you hear about us?

Website Social Media Radio TV Printed Ad Brochure/Pamphelt Hospital Word of Mouth Community Event

3. Insurance:

Primary Insurance Name: _____

Is the Patient the Policy Holder? Yes No (If Yes, skip to Member ID/Group Number)

Insurance Street Address:_____

City:_____ State:_____ Zip Code:_____

Policy Holder Name (Last, First):_____

Relationship:_____ Date of Birth:_____/_____/_____ Gender: Male Female

Home Street Address:_____

City:_____ State:_____ Zip Code:_____

Member ID:_____ Group Number:_____

Secondary Insurance Name: _____

Is the Patient the Policy Holder? Yes No (If Yes, skip to Member ID/Group Number)

Insurance Street Address:_____

City:_____ State:_____ Zip Code:_____

Policy Holder Name (Last, First):_____

Relationship:_____ Date of Birth:_____/_____/_____ Gender: Male Female

Home Street Address:_____

City:_____ State:_____ Zip Code:_____

Member ID:_____ Group Number:_____

4. Emergency Contact

Please list contact information for the person you want us to contact if there is an emergency. We will identify ourselves as Shawnee Health Care.

Name:_____ Relationship:_____

Home Phone:_____ Mobile Phone:_____

5. **Employment** (complete below): Unemployed Not Applicable

Employer Name:_____ Phone:_____

Employer Street Address:_____

City:_____ State:_____ Zip Code:_____

6. Guarantor: Patient is Guarantor (skip number 6)

Guarantor is the person responsible for the patients bill. It is always the patient unless the patient is a minor or an incapacitated adult. Guarantor is not the insurance member or head of household.

Guarantor Name:_____

Relationship:_____ Date of Birth:_____/_____/_____

Guarantor Street Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Email address:_____

7. Consents and Acknowledgements

In order for you to become a patient, we need your consent to provide you with care. We also need you to acknowledge that we have provided you with certain important information. If you have any questions about any of this information, please do not hesitate to ask a member of our staff. It is important to us that you feel comfortable with all of this information. By signing, you are indicating that you understand the information, have been given a chance to ask questions, and are giving your consent.

Consent to Treat

I voluntarily agree to receive services by physicians, dentists and other health care providers at any Shawnee Health Care (SHC) location. I understand that I should participate in planning my care and that I have a right to refuse the advice of my healthcare provider. I am aware that SHC has students/residents being trained as doctors, nurses or other health care providers who might help care for me. These students are supervised by licensed providers.

I understand that no one can be given care at SHC without first agreeing to the care unless there is an emergency.

☐ **I Accept** ☐ **I Decline**

Consent to Pay for Service and Treatment

Shawnee Health Care (SHC) participates in Medicare, Medicaid and many insurance plans and will bill your insurers if we have your current insurance information.

I agree to the release of any health information needed to process insurance claims for the health care I receive at SHC. I agree that insurance payments for these services will go directly to SHC. I understand that this agreement may not result in full payment by my insurance for the services I receive and I agree to be responsible to pay for any remaining balances.

I understand that if I do not have health insurance coverage, I am responsible for paying all charges for services and treatment by SHC. I understand that SHC offers a discount to lower income individuals and families. To receive the discount, I understand that I must apply for the program and provide information about my family size and income.

☐ **I Accept** ☐ **I Decline**

Consent to Share Medical Information and Records

I understand that Shawnee Health Care (SHC) works with other health-related agencies and shares some information with them in order to provide comprehensive care. One agency is:

- Centerstone for sharing of treatment information (if I am a patient of both SHC and Centerstone
- I agree for SHC to share my health, mental health, substance abuse, and HIV treatment information and records as needed with Centerstone in electronic, paper or telephone format.

For a list of Health Information Exchanges (HIEs) that SHC uses, please see our Notice of Privacy Practices.

☐ **I Accept** ☐ **I Decline**

Consent to Share Medical Information for Transportation

I understand that Shawnee Health Care (SHC) can help me get a ride to and/or home from my appointments. To do so, SHC may be required to disclose certain information about me. I agree and give SHC permission to share my name, appointment date, time, location, medical provider, reason for visit, physical mobility information and other necessary information such as diagnosis with transportation companies if needed to arrange transportation for me.

☐ **I Accept** ☐ **I Decline**

Consent for HIV (Human Immunodeficiency Virus) Testing

Shawnee Health Care (SHC) providers routinely test everyone between the ages of 13 and 64 for HIV at least once, as recommended by the guidance from the Centers for Disease Control and Prevention (CDC). At the time of testing, your health care provider will discuss the need and/or recommendation for HIV testing. You can discuss any questions or concerns you have with your health care provider.
This consent is also your consent for HIV testing as recommended by SHC or as requested by you. While our providers strongly encourage your participation, you may decline and not receive testing. If you decline testing, you can still receive care without any penalty from Shawnee Health Care.
SHC maintains an electronic medical record. Unlike a paper record, the electronic medical record does not allow SHC to keep your HIV/AIDS counseling and testing records separate from your medical record. All SHC employees agree to keep your information confidential and not access your HIV/AIDS testing records without your consent.

☐ **I Accept** ☐ **I Decline**

Immunization Records, Physicals, and Medication Forms

Shawnee Health Care (SHC) provides immunizations, school and sports physicals, and prescriptions to its patients. SHC and schools frequently exchange this information to facilitate your or a minor's participation in school, sports, or to receive medication while at school. By accepting below, you allow SHC to release information or exchange records with school officials and/or allow the school to release information and exchange records with SHC. The records and information include immunization records, school physicals, sports physicals, and completion of medication authorization forms sent by the school to the SHC health care provider.

☐ **I Accept** ☐ **I Decline**

Notice of Privacy Practices

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Shawnee Health Care (SHC) has our Notice of Privacy Practices available on our website and at the registration desk. This document describes in detail how information about you, the patient, can be used within our office and with others who need to know for the reasons of treatment, payment, health care operations, and as required by law. If we were to disclose your information for any other reason, we would first need your written approval. Your signature below indicates you have received a copy of the Notice of Privacy Practices.

Patient Rights and Responsibilities

I reviewed my Rights and Responsibilities as a patient of Shawnee Health Care. I was given a copy of my Rights and Responsibilities.

☐ **Yes** ☐ **No**

By signing my name below, I am acknowledging that I have read, and fully understand, each of the separate paragraphs set forth above. I understand that I can revoke my consent in writing at any time.

Patient Printed Name:_____

Date: 02/10/2022

Patient Signature:_____

Date: 02/10/2022

Parent/Guardian/Legal Guardian:_____

Date: 02/10/2022