FAMILY HealthCare

{Patient Label Here}

PATIENT FINANCIAL RESPONSIBILITY AND AUTHORIZATION FORM

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Thank you for choosing Family HealthCare. We are committed to providing you with the highest quality of service and care. We ask that you read and sign this form to acknowledge your understanding of our patient policies.

Acknowledgement and Authorization: As the patient or patient's guardian, I

- Understand the Notice of Privacy that describes the policies of Family HealthCare related to the use of care records and how to get access to this information upon request.
- Authorize Family HealthCare providers and staff to provide records acquired during my care to the insurance carrier, third party payers, and other physicians or healthcare entities that participate in my care.
- Understand that Family HealthCare respects patient confidentiality and only releases information in accordance with state and federal law.

Financial Responsibility: As the patient or patient's guardian, I

- Accept financial responsibility to pay for treatment and care received from Family HealthCare.
- Authorize assignment of payment directly to Family HealthCare and associated entities for all insurance benefits payable for services rendered.
- Agree to pay copayments at the time of service and amounts for coinsurances, deductibles and non-covered services within 30 days from receipt of my billing statement.
- Agree to participate in a Family HealthCare payment plan if I am not able to pay the billed balance in full.
- Understand that I and others on my Family HealthCare account, may be refused service or my account may be sent to collections if I am not willing to pay for the costs of services received.
- Understand that certain tests and lab services are sent outside of Family HealthCare and I will be billed separately by the outside entity for these services.

Consent for Treatment: As the patient or patient's guardian,

- Request and authorize Family HealthCare to accept me and/or my child as a patient to provide the services and care identified in the course of assessment and evaluation.
- Understand that this form will be a part of the records until such time as I may choose to revoke this acknowledgement. If I am not the patient, I represent that I am authorized by law to act on the patient's behalf.

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_____ _____

Patient/Legal Guardian Signature **Date**

_____ _____

Legal Guardian Name Printed **Relationship to Patient**

FAMILY HealthCare

Patient Registration Information

Patient Information

Patient Name: _____ Date of Birth: _____

Parent Name (if child)_____ Parent Name (if child)_____

Home Address: _____ Apt #:_____

City, State and Zip: _____ Home Number:_____

Email Address: _____ Cell/ Mobile Number:_____

Marital Status: [ ] Single [ ] Domestic Partner [ ] Married Gender at birth: [ ] Male [ ] Female

Social Security #: _____ Primary Language: _____ Interpreter needed:[ ] Yes [ ] No

Persons in Family/Household: _____ Income Amount: $_____ [ ] Weekly [ ] Monthly [ ] Annually [ ] Decline

Do you have insurance? [ ] Yes [ ] No ***We offer a discount program to those who qualify, ask us for more information.*

Emergency Contact:

Name: _____ Contact Number: _____

Relationship to patient: _____

Guarantor / Person Responsible for Charges (if different then information above)

Name: _____ Date of Birth: _____Social Security #: _____

Relationship to Patient: _____ Contact Number: _____

Address: _____ City, State and Zip: _____

Employer Name: _____ Employer Phone Number: _____

Primary insurance:

Insurance Company Name: _____

Subscriber ID#: _____

Group ID#: _____

Secondary Insurance:

Insurance company name: _____

Subscriber ID#: _____

Group ID#: _____

Additional Information

Race:
[ ] American Indian/ Alaskan Native
[ ] Asian
[ ] White
[ ] Black/ African American
[ ] Native Hawaiian
[ ] Other Pacific Islander
[ ] Choose Not to Disclose

Ethnicity:
[ ] Hispanic or Latino
[ ] Non- Hispanic or Latino
[ ] Choose not to disclose

Veteran Status:
[ ] Yes, Veteran
[ ] Not a Veteran

Education Completed:
[ ] High School
[ ] College Degree
[ ] Graduate Degree
[ ] None of the above

Farm Work Status:
[ ] Seasonal
[ ] Year round
[ ] Migrant
[ ] None of the above

Are you homeless?
[ ] Yes [ ] No
If Yes: Where do you stay?
[ ] Homeless Shelter
[ ] Transitional Housing
[ ] Doubling Up
[ ] Street
[ ] Supportive Housing
[ ] Other

Gender Identity:
[ ] Male
[ ] Female
[ ] Transgender male to female
[ ] Transgender female to male
[ ] Other/Neither Male or Female
[ ] Choose not to disclose

Do you identify as:
[ ] Straight
[ ] Lesbian or Gay
[ ] Bisexual
[ ] Something Else
[ ] Do not know
[ ] Choose not to disclose

Preferred Pronoun:
[ ] He, Him, His
[ ] She, Her, Hers
[ ] They, Them, Theirs
[ ] Other: _____
[ ] Choose not to disclose

By signing you are verifying all information above is true and correct.

Patient/Legal Guardian Signature _____ **Date:** _____