SISKIYOU COMMUNITY HEALTH CENTER
Patient Registration

Welcome to Siskiyou Community Health Center. We are committed to providing quality, cost-effective health care for you and your family. Please feel free to speak with your provider if you have any questions about your care. If you have any questions about clinic policies or procedures, please speak with the clinic manager.

1 PATIENT DEMOGRAPHICS

Full Name _____ SSN # _____ Birth Date_____

Billing Address _____ City_____ State_____ Zip_____

Home Address _____ City_____ State_____ Zip_____

Day Phone _____ Home Phone _____ Email _____

Employer_____ Phone_____

Emergency Contact Name/Relationship _____ Phone_____

Name of Spouse/Significant Other**_____ Date of Birth_____

Social Security #_____ Phone _____ Employer _____

If you would like this person to be able to discuss your medical care and/or billing issues, please request an Authorization Form.

Primary Language: English Spanish Sign Language Other **Do you need an interpreter?:** Y N

Marital Status: Single Married Widowed Divorced Separated Domestic Partner

Employment Status: Employed Disabled Retired Unemployed Homemaker Student

Highest Grade Completed: _____ **Veteran:** Y N **Smoker:** Y N

Gender Identity: Female Male Transgender F to M Transgender M to F Other Declined

Sexual Orientation: Bisexual Don't Know Lesbian or Gay Something Else Straight (not Lesbian or Gay) Declined

2 INSURANCE INFORMATION - Please provide your insurance card(s)

Name of Primary Insurance_____ Policy #_____

Policyholder Name_____ Date of Birth_____

Name of Secondary Insurance_____ Policy #_____

Policyholder Name_____ Date of Birth_____

3 MINOR PATIENTS ONLY -ADDITIONAL INFORMATION

Mother's Name_____ Mother's Employer_____

Mother's Date of Birth_____ Social Security #_____ Day Phone_____

Mother's Address_____

Father's Name_____ Father's Employer_____

Father's Date of Birth_____ Social Security #_____ Day Phone _____

Father's Address_____

4 PATIENT STATISTICS

As a Federally Qualified Health Center, we are able to offer services to all our patients, including the underserved, as a result of funding from Federal Grants. In order to receive grant dollars we are required to gather, on a yearly basis, the following statistics about the patients we serve. This information is confidential and will be used for statistics purposes only. We appreciate you taking the time to fully complete all questions in this section.

What is your living status? ____ Homeless ____ Not Homeless

What is your Migrant Worker Status? ____ Farm Worker ____ Not a Farm Worker

What is your Race? *(mark all that apply)*
____ American Indian/Alaska Native ____ Asian ____ Black/African American
____ Caucasion/White ____ Native Hawaiian ____ Other Pacific Islander

What is your Ethnicity? ____ Hispanic/Latino ____ Other

What is your Gross Annual Household Income? _____ **How many people are in your household?** _____

5 BILLING AND COLLECTION POLICY

Payments of copays, deductibles and any other amount not covered by insurance is expected at the time of service. Any amount not received at your appointment will be billed on your monthly statement. All statements are due in full upon receipt unless prior financial arrangements have been made. Unpaid balances will be subject to our collection process, which may include assignment to an outside collection agency and possible discharge from the practice for failure to comply with policy.

We will submit a claim to all contracted primary and secondary insurance companies with the exception of motor vehicle claims and out-of-state worker's compensation claims. It is your responsibility to supply us with a current copy of your insurance card(s) at each appointment.

Whenever possible, patients will be advised of the cost of services prior to treatment. We do offer a sliding fee discount based on your income and family size. Please ask our front desk staff for an application.

The Billing Office is open Monday through Friday, 8:00 am to 5:00 pm. We accept all major debit/credit cards, checks, cash and Care Credit at our Dental facility. A $29 NSF fee will be applied for all returned checks.

I hereby authorize Siskiyou Community Health Center to provide services to the above named patient and to use and release medical or dental information as required for treatment, payment and health care or dental operations. I also assign Siskiyou Community Health Center payments to which I'm entitled for medical, surgical, behavioral health and dental expenses. I have read and understand the above policy regarding my financial responsibility for all services provided whether covered by insurance or not.

_____ _____

Patient or Patient Representative Signature **Date**

6 NO SHOW POLICY

An appointment that is not kept, not canceled 24 hours in advance, or is late is called a "No-Show". If you are unable to be at your appointment, it is your responsibility to call and reschedule or cancel the appointment.

New Patients – Failure to confirm or cancel your new patient appointment at least 24 hours prior to the appointment time will result in a "no-show" status. New patients that fail to provide appropriate cancellation notice for two (2) appointments will no longer be eligible to establish care with us for twelve (12) consectutive months.

Established Patients - If an established patient "No-Shows" four (4) times, they will be notified that they are no longer eligible to schedule future appointments and will be seen in the clinic on a *same day basis* only.

I have read and understand this "No-Show" policy.

_____ _____