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 _____ Nickname _____

SSN_____ Date of Birth_____ Birth Sex ☐Female ☐Male

Billing Address _____ City_____ State_____ Zip_____

Home Address _____ City_____ State_____ Zip_____

Home Phone _____ Day Phone _____ Cell Phone _____

Preferred Notification for Reminders ☐ Phone Call ☐ Text Message ☐ Opt Out (No Reminders)

Emergency Contact Name/Relationship _____ Phone_____

Marital Status ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated ☐Domestic Partner

Primary Language ☐English ☐Spanish ☐Sign Language ☐Other_____Do you need an interpreter? ☐Yes ☐No

Name of Spouse/Significant Other**_____

SSN_____ Date of Birth_____ Phone _____

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

Primary Pharmacy_____ Secondary Pharmacy _____

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

Mother's Name_____Date of Birth_____ SSN_____

Address_____ Phone_____

Father's Name_____ Date of Birth_____ SSN_____

Address_____ Phone_____

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, 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 **Are you a Migrant Farm Worker?** ☐Yes ☐No

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

What is your Ethnicity? ☐Not Hispanic/Latino ☐Hispanic/Latino **Are you a Veteran?** ☐Yes ☐No

Gender Identity? ☐Declined ☐Female ☐Male ☐Transgender F to M ☐Transgender M to F ☐Genderqueer ☐Other

Sexual Orientation? ☐Declined ☐Straight/Heterosexual ☐Lesbian/Gay ☐Bisexual ☐Something Else ☐Don't know

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

What is your employment status? ☐Employed ☐Homemaker ☐Retired ☐Student ☐Unemployed ☐ Disabled

If over age 18, what is the highest grade in school you completed? ☐Elementary ☐6th ☐7th ☐8th ☐9th ☐10th ☐11th ☐12th ☐GED ☐Attended College ☐ Associate's Degree ☐Bachelor's Degree ☐Master's Degree

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.

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. 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.

_____ _____

Patient or Patient Representative Signature **Date**