|  |
| --- |
| ***PATIENT REGISTRATION*****Processed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Processed: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_** |

 

***\*\*Please present your insurance card(s) and photo identification to the front desk along with this form.\*\****

**Name**:

Last First Middle

**Date of birth**: / /

**Social Security #**:

**Sex**: M

F **Preferred Name:\_\_\_\_\_\_\_\_\_\_\_\_**

**Marital Status:** Single Married Divorced Separated Widowed

 **Street address**:

**PO Box**: **City: State: Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone Home/Cell**: ( ) **Work**: ( ) **Email**:

**Student**:

Full Time

Part Time **School**:

**Primary language**:

**As a Federally Qualified Health Center, UHC is required to collect demographic information regarding the patients we serve. The information you provide is confidential. Please check** Choose Not to Report **if you do not wish to answer a specific question.**

**Race (check one)** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ More than one race ☐ Native Hawaiian Other Pacific Islander ☐ White/Caucasian ☐ *Choose not to report*

**Ethnicity (check one)** ☐Hispanic/Latino ☐Not Hispanic/Latino ☐ *Choose not to report*

**Sexual Orientation**:

* Straight (not lesbian or gay) ☐ Lesbian or gay ☐ Bisexual ☐ Something Else ☐ Don’t Know ☐ *Choose not to disclose*

***G*ender Identity:**

* Male ☐ Female ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to -Female ☐ Other ☐ *Choose not to disclose*

**Are you a US Veteran?** Yes ☐No **Do you live in public housing?** Yes ☐No

**Housing for patient or patient’s parent/guardian, if a minor** – Please check one

Rent or own home

Homeless Shelter

Transitional

Street

Doubled Up (live with another person or family unit)

Other \_

*Chose not to disclose*

|  |  |
| --- | --- |
| **Annual Family Income** (Gross) - Please check one |  |
| ☐$12,140 or below ☐$12,141 - $16,460 ☐$16,461 - $20,780 | * $20,781 - $25,100
 | * $25,101 - $29,420
 | * $29,421 - $33,740
 |
| ☐$33,741 – $38,060 ☐$38,061 - $42,380 ☐$42,381 – $46,700**Family size:** ☐ *Choose not to disclose* | * $46,701 - $51,020
 | * $51,021 - $55,340
 | * $55,341 - over
 |

**Spouse’s name**: **Date of birth**: / / **Spouse’s Telephone:** ( ) **Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In case of EMERGENCY, we may contact: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone: ( ) Rel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Guarantor Information**: (Person who pays the bill?) Name: Telephone: ( ) Work phone: ( ) Relationship Address: City State Zip Code Employer: Social Security number: Date of birth: / /

**If Patient is a Minor:** (Please complete this section)

**Parent/Legal Guardian (1) Full Name**:

**Telephone**: ( )

 **Relationship to Patient**: **Date of Birth**: / / **Work Phone**: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Legal Guardian (2) Full Name**: **Telephone**: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient**: **Date of Birth**: / / **Work Phone**: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Non-Parent/Legal Guardian Designee** (authorized to accompany minor**) Full Name: Rel**:

**(\*The information listed above is Not authorization for a personal representative. A HIPAA release MUST be signed to discuss ANY information.)**

**By checking this box, I acknowledge I have been offered an application for the slide discount program (UHC) and DO NOT want to participate.**

I certify that the information given above is true and correct.

 \_ / /

(Patient Signature or Parent/Guardian signature, if patient a minor) (Date)

Rev. 02/09/2022

# United Health Centers

# About Our Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

* 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.

It is our policy to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

# Patient Acknowledgement of Receipt

I, , hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

Patient’s Signature Date

Signature of Parent or Patient’s Representative (if applicable) Date

Description of Legal Authority to Act on Behalf of Patient

Rev. 02/09/2022



## United Health Centers

**Conditions of Examination**

**Contact Information and Instructions**

*In order to provide you with quality health services with respect for your privacy, we ask that you instruct us on how to get in touch with you to discuss matters such as important lab results and medical follow up, appointment scheduling, billing issues, pharmacy refill orders or potential drug recalls.*

**Telephone:**

**Written Communication**

 OK to leave message with detailed information

 Leave message with call back number only

 Mail to home address (such as postcards or letters).

 Mail to work/office

Home #: ( )

Work #: ( )

Cell #: ( )

Text #: ( )

Address: \_

Email:

#### Consent for Examination and Treatment

I give the designated personnel of United Health Centers, my consent for examination, ordering of appropriate lab test(s), diagnostic procedures and prescribing medication and treatment for

 **Patient’s Name**

All procedures will be explained to me. I will have a chance to ask questions about advantages, alternatives, and possible adverse effects.

This consent is valid until revoked.

#### Responsibility for Payment of Bill:

I, the undersigned, understand that I am financially responsible for the services received by the patient and authorize United Health Centers to release any medical information required to receive payment for services rendered to the patient.

#### Beneficiary Agreement:

I request payment of authorized benefits by my insurance carrier be made on my behalf to United Health Centers for services rendered to me by United Health Center, I understand that this request is valid until revoked by me and that I am responsible for any deductibles and co-insurance of allowable charges not otherwise covered.

#### Content of Form:

I certify that I have read this form and understand its contents and that the information given by me is true and correct.

**Date:**

**Signature:** \_ If minor, parent/legal guardian’s signature is required.

**UHC Staff:**

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## CONSENT TO COMMUNICATE PROTECTED HEALTH INFORMATION TO AN AUTHORIZED PERSON

Date of Birth:

Patient name (please print):

I give permission for United Health Centers to VERBALLY share the information I have described below to be released to the persons I have identified below. **This form does not authorize releasing copies of my medical records**.

### \*I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 CFR Parts 160 & 164 and state confidentiality law governing behavioral health/substance abuse services (GS 122C) cannot be disclosed without my written consent unless otherwise provided or in the regulations. I understand that the information to be released may contain information regarding alcohol abuse, drug abuse, HIV infection, AIDS or AIDS related conditions, psychological, psychiatric or physical limitations.

I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it. I understand that UHC may not condition my treatment based on the signature of this form.

Indicate each person that you approve:

Name: Phone: Relationship: ☐ Family ☐ Friend ☐ Caregiver ☐ Other Provider: ☐ Other:

This consent expires one year from date executed unless other noted here: \_/ \_/ \_

Patient signature:

Printed name: Date: \_

### REVOCATION SECTION

I do hereby request that this authorization to disclose health information of

(Name of Client) signed by (Enter Name of Person Who Signed Authorization) on (Enter Date of Signature)

 be rescinded, effective . I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

Signature of Patient Date

Signature of Witness Date

MR 10.01

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