Memphis Health CENTER

PATIENT REGISTRATION FORM

(Please Print Clearly)

PATIENT INFORMATION

Patient's Last Name	First:	Middle:	Have You Been a Patient Here Before: ☐ Yes ☐ No

Home Address:	Apt/Suite:	City:	State:	Zip Code:

Sex: ☐ M ☐ F	Birth Date:	Social Security #:	Phone Number:	Marital Status: ☐ Single ☐Married ☐Divorced ☐Other

EMERGENCY CONTACT

Name:	Relationship to Patient:	Address:	Phone Number:

RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)

Name:	Relationship to Patient:	Address:	Phone Number:

INCOME INFORMATION

Employer:	Employer Address:

Income	Relationship	Age	Gross Monthly Income	Total Persons
				Total Gross Income

INSURANCE INFORMATION

Is this Patient Covered by Insurance: ☐ Yes ☐ No (If you checked 'No' please skip this section)

Please indicate Primary Insurance: ☐ Medicare ☐ SCHIP ☐ TN Care ☐ Other _____

Person Responsible for Charges:	Birth Date	Address: (if different):	Home Phone Number:

Subscriber's SSN:	Group Name:	Group Number:	Policy Number:	Co-Payment: $

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Insurance:	Subscriber's Name:	Subscriber's SS#:	Birth Date:	Group Number:	Policy Number:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Preferred Language: ☐ English ☐ Spanish ☐ Other _____	Are You a Veteran of the Armed Forces: ☐ Yes ☐ No	Are You Homeless: ☐ Yes ☐ No

Race: ☐ White ☐ Asian ☐ African American ☐ Pacific Islander ☐ American Indian ☐ More Than One Race ☐ Unknown	Latino/Hispanic Descent: ☐ Yes ☐ No

How Did You Hear about MHC? ☐ Relative/Friend ☐ School ☐ Hospital ☐ Church ☐Direct Mail ☐ Internet

☐ Magazine ☐Newspaper ☐Radio ☐ A Step Ahead ☐CAAP ☐Health Fair/Community Event ☐Other: _____

INSURANCE ASSIGNMENT

I hereby authorize: (a) payment of insurance benefits otherwise due to me be made directly to Memphis Health Center (b) release of information, including protected health information to insurance companies as needed to file for payment services incurred; (c) Memphis Health Center to obtain records from other sources as may be necessary in the diagnosis or treatment and (d) understand that I am financially responsible to Memphis Health Center for charges related to services provided or incurred by me or the party I am responsible for.

I certify that all statements made in this form are true, complete and accurate to the best of my knowledge. I understand that the sliding fee discount will expire six (6) months from this date.

Signature _____ Date _____

Patient Name _____ **D.O.B.** _____

CONSENT FOR MEDICAL TREATMENT

The undersigned, (parent or legal guardian), consents to the administration of reasonable and necessary surgical services in connection with treatment of the named patient at Memphis Health Center (MHC). This consent includes, but is not limited to, laboratory procedures, radiological procedures, medication administration, anesthesia, surgical procedures and/or other service rendered the patient by members of the Medical Staff, their representatives an/or associates and health center employees under the instruction of the physician or dentist. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examination in the Center.

ADVANCE DIRECTIVE ACKNOWLEDGMENT

Do you have an Advance Directive? ☐ Yes ☐ No

Please read the following four statements and place your initials in front of each statement as it applies to you:

1. _____I have been given written materials about my rights to accept or refuse medical treatment.
2. _____I have been informed about my rights to formulate an Advance Directive.
3. _____I understand that I am not required to have an Advance Directive in order to receive medical treatment at Memphis Health Center or its satellite clinics.
4. _____I understand that this health care facility and my caregivers will follow the terms of any Advance Directive that I have executed to the extent permitted by law.

Basic life support will be initiated until emergency medical teams (EMT) arrive. A copy of the Advance Directive Acknowledgment will accompany the patient to the hospital.

ABOUT OUR NOTICE OF PRIVACY PRACTICES

We are committed to protecting your personal health information in compliance with the law. MHC Notice of Privacy 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

We are required by law to give you a copy of this notice and obtain your written acknowledgement that you have received a copy of the Notice.

USE OF ELECTRONIC COMMUNICATIONS

(Check the Correct Option)

○ I understand that MHC and I may exchange information via e-mail or text message, per my request:
- ○ I do wish to have MHC contact me via e-mail. This may include appointment confirmations. My email address is: _____.
- ○ I do wish to have MHC contact me via text message. My cell phone number is: (____) ____-_____.

○ I do not wish for MHC to contact me via email or text message.

PATIENT ACCEPTANCE

I, _____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices, I have completed the consent for medical treatment, received information on Advance Directives and have completed and understand the use of electronic communications.

- ○ Memphis Health Center uses Social Security Numbers to obtain income information for persons who want benefits
- ○ Memphis Health Center does not report to the U.S. Department of Homeland Security

Patient's Name: _____

Signature of Patient's Representative: _____

Description of Legal Authority to Act on behalf of the Patient: _____Date: _____

FOR OFFICE USE ONLY

Reviewed by: _____ Date:_____ Initial: _____

PATIENT NAME: _____ **D.O.B.** _____

FINANCIAL INFORMATION

Monthly Income (List source of monthly income BEFORE taxes and for All household members)

Income Source	Amount	Income Source	Amount
Wages/Salary of Client		Housing Assistance- Amount HUD Pays	
Wages/Salary of Husband/Wife		Social Security Income	
Wages/Salary of Partner		Disability Income	
Wages/Salary of Parent/Guardian		Other Income Pension/Veteran/Retirement	
General Assistance-or AFS/AFDC		Other Income Alimony/Child Support	
Worker's Compensation		Other Income Dividend/Interest Investment	
Unemployment		Other Source-Relationship to Client	
Total Monthly Income		**Total Monthly Income**	

Family Household Size: _____

FINANCIAL AGREEMENT: The undersigned SEVERALLY agree, whether signing as a patient or otherwise, that in consideration of the services rendered to patient of the account is guaranteed by the undersigned in accordance with the regular rates and terms of the center and other medical providers, and is payable to the center and other medical providers. While any insurance or other protection related to the account of the center and other medical providers may be hereby assigned to and payable directly to the center and other provides, the undersigned clearly understands that the obligation to pay the center and other medical providers is primarily on the patient and the undersigned, and while insurance received by the center and other medical providers will be applied to the patient's account, any part of the account not so paid by insurance is nevertheless owing and payable. In case of default of payment, and if these accounts should be placed in the hands of a Collector, or an Attorney for collection, all collection fees, attorney fees (which shall equal one-third of any balance due), cost and other expenses will be paid by the undersigned. Notice of dishonor, demand and protest are waived. It is further agreed that due to the high cost of billing and refunding small amounts, the center will not bill or refund underpayments or overpayments of less than five dollars ($5) on final balances, except on a request of the patient or responsible party.

PERMISSION TO RELEASE PATIENT INFORMATION

Memphis Health Center (MHC) is hereby authorized to disclose all and/or any part of the patient's medical record to any person which is or may be liable for or responsible for payment of any of the charges of the center and/or medical providers, including but not limited to, insurance companies, medical or hospital services companies, worker's compensation carriers, employers and welfare funds. I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare or Medicaid/TennCare claim.

Patient at Memphis Health Center consents to disclosure of information for purposes of treatment, payment and health care operations. Patient may consent to receipt or disclosures of health care information for other purposes as well.

If you have a spouse, friend or relative that may call on your behalf to obtain appointment dates and time, test results, etc., we will not give that information out unless his/her name(s) is provided for our records. I hereby give permission to the MHC to allow receipt of the following to those listed below should he/she call or come in to inquire. Please check what you will allow to be released.

- ○ Medical Test Results
- ○ Medications
- ○ Appointment Confirmation
- ○ Other _____

Name: _____ D.O.B. _____ Relationship: _____
Name: _____ D.O.B. _____ Relationship: _____

○ I **do not** consent to information about me to be released to others, except as I have consented, or may in the future consent in other authorizations or consents provided to me by Memphis Health Center, or as required by law.

The above conditions apply to all areas within the center and this form is valid at each site. The release of information set forth herein above is valid for one year from date of services, and the assignment of insurance benefits and financial agreement is valid and binding until final settlement of the account is received. Further, I agree that the terms of this agreement shall apply to all subsequent and future services rendered to me, my spouse, or my dependents by the center and other medical providers unless this agreement is revoked by written notice sent certified mail prior to the subsequent date of services.

Patient's Signature (or Representative/Surrogate decision maker) for consent to treatment and release of information:

_____
Signature Date Time

Responsible Policyholder's Signature for Insurance Assignments:
(1) _____
(2) _____