Memphis Health CENTER
www.memphishealthcenter.org

Dear Patient,

Thank you for becoming a new patient or recertifying your registration with Memphis Health Center (MHC)! We are very excited to have the opportunity to serve you and your family with the most comprehensive and high-quality array of primary medical and social support services available throughout the Mid-South!

MHC provides the following primary care and ancillary services:

Pediatric/Adolescent	Radiology
Adult Medicine	Mammogram
Obstetrics/Gynecology	Pharmacy
Behavioral Health	Laboratory
Dental	Podiatry
Ophthalmology	Telehealth

As a patient receiving care at MHC, you also have access to enabling/social services and value-added programs.

Enabling/Social Services	**Value-Added Programs**
Case Management	Sliding Fee Discount
Translation/Interpretation	Women, Infant, and Children (WIC)
Transportation	Healthcare For Homeless
Eligibility/Enrollment Assistance	Ryan White Part A & MIA
Health Education	340B Discount Prescription Drugs
Medication Assistance	A Step Ahead
Housing Assistance	TN Breast/Cervical Cancer Screening

Please note the items below that are required to complete your registration:

Adult (18 years & older)
- ✓ **Two (2) Valid Forms of Identification (One MUST be a Photo ID)**
- ✓ **Insurance Card**
- ✓ **Income Verification (If Applicable)**

Minors (0 to 17 years)
- ✓ **Two (2) Valid Forms of Identification (Parent)**
- ✓ **Insurance Card**
- ✓ **Income Verification (Parent If Applicable)**
- ✓ **Birth Certificate**
- ✓ **Social Security Card**

To schedule your next appointment or for more information about our services and programs, please call (901) 261-2000 during regular business hours or request an appointment online at www.memphishealthcenter.org. If you need medical care after hours of operation, please call (901) 261-2000.

Hours of Operation:
Monday & Wednesday: 7:30 AM to 7:30 PM
Tuesday & Thursday: 7:30 AM to 5:30 PM
Friday: 7:30 AM to 11:30 AM
Saturday: 8:00 AM to 12:00 PM

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:

Marital Status: Single Married Divorced Other	Birth Date:	Social Security #:	Phone Number:	Gender: Male Transgender Male Other:_____ Female Transgender Female Refuse to Answer

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

Sexual Orientation: Straight (Not lesbian or Gay) Lesbian or Gay Bi-sexual Don't Know Refuse To Answer

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

_____, 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.

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

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

o **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

SLIDING FEE – INCOME VERIFICATION

I, (Patient Name) _____ (Date of Birth) _____

understand that I am applying for a sliding fee discount for eligible services provided by Memphis Health Center, Inc. I am applying for the sliding fee discount because I am either uninsured or my current coverage is not enough for the services needed. As part of the sliding fee discount program I am responsible for providing proof of my annual household Income and the number of people living in the home. I understand this is not just my income but the total income of all working individuals in the home where I live.

My household income is $ _____ every week/month/year.

There are_____ people that live in my home.

As proof of income I have provided at least one of the following items:

❑Most recent pay check ❑Most recent W2 form

❑ Proof of government assistance (food stub (Full month) stamps, social security, disability, other)

I understand it is my responsibility to provide an update to Memphis Health Center, Inc. at any time my income or my Insurance status changes. Changes in Insurance and/or income status may affect the amount of your financial responsibility. I agree, at a minimum, I will provide updated income verification annually or at the request of the Memphis Health Center, Inc.

PAYMENT OF SERVICE

Payment for services is expected at the time of the visit Payments are collected upfront prior to every visit Payments may vary by site and by service. All balances are expected to be paid within 30 days. Balances beyond 30 days are required to have a payment plan on file with the Finance Department. All balances exceeding 60 days or $100 may be placed into collection status. Accounts In collection status may require payment up front prior to services being rendered until the balance is cleared.

NO PROOF OF INCOME: I understand that I have not provided proof of household Income at this visit. For this reason, will be charged at **FULL PRICE.** I understand that my visit today will require an upfront minimum payment (generally $25-$120), depending on the services needed, and that there may be additional charges based on my completed visit. Payment plans are handled on a case by case basis.

_____ Patient Signature _____ Date

_____ MHC Staff Signature _____ Date

Patient Initials

ZERO INCOME – SELF DECLARATION PLEASE
FILL OUT ONLY IF YOU HAVE NO SOURCE OF INCOME

Name of last employer: _____ Date of last employment: _____

PLEASE INDICATE YOUR CURRENT LIVING ARRANGEMENTS:

_____ I am presently in a Homeless Shelter: Name of Shelter: _____

_____ I am presently DOUBLING UP – Live with relative / friend FREE of Charge (You must Present Proof)

_____ I am presently TRANSITIONAL (i.e. Halfway House) Name of Transitional Home: _____

_____ I presently OWN or Renting my own home or space.

I, _____, certify that I have had **$0.00** source of income since _____.

Truth of Statement & Acknowledgement

I understand that I have not provided income documentation at the time of services and that I am requesting to be allowed to utilize MHC 1 time self- declaration waiver for services today. I understand and accept that this is only good for a one time use per patient at the point of service rendered for the day and if proof of income is not provided after this visit I will be charged at 100% of services for my next visit

The facts set forth in this application are true and complete to the best of my knowledge. I understand and accept the fact that a false or incomplete statement on this application will be cause for rejecting my application, at which point I will be responsible for 100% of any medical or dental expenses accrued at Memphis Health Center, Inc.

_____ _____

Witnessed by & date Patient signature & date

Sliding Fee Disclosure

The income guidelines change annually. Re-evaluation for sliding fee is required if there is a change in your income status during the year. You are required to have your application updated **annually** even if your income has remained the same or **biannually** if you have zero income. Failure to comply will result in **FULL CHARGE** for services rendered.

Effective Date: _____ End Date: _____

I understand that if I do not provide the required documentation, I can continue to receive my health care services at this center, but I will have to pay 100% of my medical/dental bill.

Patient Signature: _____ Date: _____

MHC Signature: _____ Date: _____

Verification Checklist	Yes	No
Identification: Driver's license, social security card, passport, or other		
Proof of Residence: Utility bill, cable bill, vote of registration card, or other		
Income: Prior year tax return, proof of income, or other		
Insurance: Insurance Cards		