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

PATIENT INFORMATION

Last Name	First Name	Middle Name	Preferred Name

Date of Birth / /	Social Security Number	Gender ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated

Mailing Address (Street or P.O. Box)	Apt.	City	State	Zip Code

Home Phone Number ( )	Cell Phone Number ( )	Email Address

Emergency Contact Name	Relationship to Patient	Emergency Contact Phone Number ( )

Do you have an Advance Directive/Living Will? ☐ Yes ☐ No	Do you desire to create an Advance Directive/Living Will? ☐ Yes ☐ No	What is your primary language? ☐ English ☐ Spanish ☐ Other_____

RESPONSIBLE PARTY (Complete if different from above)

Last Name	First Name	Relationship to Patient ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Guardian ☐ Child ☐ Other_____

Date of Birth / /	Social Security Number	Gender ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated

Mailing Address (Street or P.O. Box)	Apt.	City	State	Zip Code

Home Phone Number ( )	Mobile Phone Number ( )	Work Phone Number ( )	Email Address

Primary Insurance Company	Policy/Member ID #	Policy Group #	Copayment

Secondary Insurance Company	Policy/Member ID #	Policy Group #	Copayment

DEMOGRAPHIC INFORMATION

Our federal grant requires us to collect and report on the information below in an effort to provide culturally competent healthcare services. The information is reported on the population, not by specific individuals.

Annual household income_____
This is used to assess your need for, and ability to qualify for, financial assistance programs.

How many dependents are in your home, including you? (yourself, spouse/partner, and minor children under 18 years) _____

Are you in need of financial assistance? ☐ **Yes** ☐ **No**

Are you homeless? ☐ **Yes** ☐ **No**
(please check the box that best describes your household)
☐ Shelter
☐ Transitional
☐ Street
☐ Doubling up (with family/friends)

Veteran Status (Have you ever served in the U.S. Military?)
☐ **Yes** ☐ **No**

Are you a migrant or seasonal worker?
☐ **Yes** ☐ **No** (if yes, which one_____)

Race (Please check ALL that best describes your race)
☐ Alaska Native
☐ American Indian/Alaska Native
☐ Asian
☐ Black/African American
☐ Native Hawaiian
☐ White
☐ Other Pacific Islander
☐ Korean
☐ Chose not to disclose

Ethnicity
☐ Hispanic/Latino
☐ Not Hispanic/Latino
☐ Mexican
☐ Mexican American, Chicano
☐ Cuban
☐ Chose not to disclose

Gender Identify
☐ Male ☐ Female ☐ Transgender Male
☐ Transgender Female ☐ Other
☐ Chose not to disclose

Sexual Orientation
☐ Heterosexual ☐ Lesbian or Gay
☐ Bisexual ☐ Other ☐ Don't Know
☐ Chose not to disclose

How did you hear about MHC?
Relative/Friend; Community Event; Radio/TV; Other _____

**Please provide your current address, phone number, and insurance card(s) at each appointment.*

CONSENT FOR EVALUATION AND TREATMENT

Memphis Health Center (MHC) is committed to providing comprehensive primary care, dental, and behavioral health services. Because collaborative, patient-centered care plays an integral role in the care you receive, our multi-disciplinary team of providers works together to ensure your needs are being addressed and to offer you high-quality whole person healthcare.

Some services at MHC may involve the use of telemedicine equipment and interaction with providers who are not physically onsite. These sessions are transmitted via secure, dedicated high-speed lines and are not videotaped, routed through the internet, or saved in any way.

I understand, that if I am 13 years of age or older, I may consent for family planning or obstetrical services; if I am 16 years of age or older, I may consent for certain types of health services, including mental health services; and if I am 18 years of age or older, I may consent for all other health services; otherwise, my parent or legal guardian will need to consent to services.

I hereby authorize the providers of MHC to provide reasonable and necessary medical, dental, and behavioral health services in connection with evaluation and treatment of the named patient.

Thus, I hereby ask, agree, and consent to evaluation and treatment for myself and/or child(ren) as set forth above, including any tests or procedures that MHC professional staff decide are necessary or appropriate. If signing as parent or legal guardian, I hereby represent and warrant that I am legally empowered and entitled to make such decisions.

By signing this form, (parent or legal guardian, if required) I agree that I have read or had this form read and/or explained to me, that I understand it and that any questions I asked have been answered. I understand that I agree to be truthful in providing information.

Patient Name: _____ **Patient DOB:** _____

Signature: _____ **Date:** _____

Printed Name if Parent/Guardian Signing: _____

NOTICE OF PRIVACY PRACTICES

Memphis Health Center (MHC) strongly believes in safeguarding the privacy of our patients' protected health information (PHI). PHI is information which:

- Identifies you (or can reasonably be used to identify you); and
- Relates to your physical or mental health condition, the provision of health care to you or the payment for that care.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. This Notice of Privacy Practices describes how we may collect, use and disclose your PHI, and your rights concerning your PHI.

You will be provided with a copy of the Notice of Privacy Practices during the registration process. The Notice is also posted on our website at **www.memphishealthcenter.org**.

My signature below serves to confirm I have received the Notice of Privacy Practices and information on how to obtain a copy of the MHC's Notice of Privacy Practices.

_____ _____ _____

Patient Name (Print) **Signature of Patient** **Date**

SLIDING FEE DISCOUNT PROGRAM APPLICATION

It is the policy of Memphis Health Center (MHC) to provide services regardless of the patient's ability to pay. As a Federally Qualified Health Center, MHC offers a Sliding Fee Discount Program designed to allow patients to pay for healthcare services based on family size and household income. Sliding Fee Discounts are determined by using:

Recent Income Tax Return	Recent W-2 Form	Current Pay Stubs
Unemployment Award Notice	Social Security Notice	Self-declaration Letter

To apply for the Sliding Fee Discount Program, please complete the following information and return to the front desk with proof of household income and photo identification. To remain eligible for the discount, this form must be completed every 12 months or if your family/financial situation changes.

PATIENT INFORMATION

Last Name	**First Name**		**DOB**	
Mailing Address (Street or P.O. Box)	**Apt.**	**City**	**State**	**Zip Code**
Home Phone Number ( )	**Cell Phone Number** ( )		**Email Address**	

Please list all household members, including those under the age of 18 and income.

Household Members	Number	Gross Income (Before Taxes)
Total Household Members/Gross Income		

I understand that if I am applying for financial assistance and do not have any source of income or do not have proof of income with me today, MHC will discount my services for today based on estimated income. **However, I will be totally responsible for any subsequent visits at MHC if I do not bring proof of income within 30 business days**.

I, _____ (print name), certify that the above information is true and correct to the best of my knowledge. I agree to notify MHC if there are any changes in my household size or income. If the above information proves to be incorrect, I understand that the discount provided to me will be terminated.

_____ _____

Patient (Legal Guardian) Signature **Date**

FOR OFFICE USE ONLY			
Verified By	**Effective Date**	**Expiration Date**	**Sliding Fee Scale (circle one)** A B C D E F

SELF-DECLARATION OF INCOME FORM

Complete the information below only if you have no other way to document your income. Failure to complete this form may result in denial of your application from the Sliding Fee Discount Schedule Program.

Check all that applies:

□ I am currently unemployed.

□ I get paid in cash.

□ I do not get pay checks.

□ I do not get pay stubs.

□ I cannot get a letter from my employer establishing my income. **Explain why:** _____

_____

My gross household income is $_____ (circle one: per week / month / year) and there are _____ family members living in my household.

Current Employer _____

Employer Address _____

Employer Phone Number _____

I certify that I have no other way to document my income and that all the above information is true and correct. I understand that this information is to be used to determine eligibility for the Sliding Fee Discount ("SFD") Program. I understand that Memphis Health Center may verify information on this form. I also understand that if I intentionally misrepresent my income, I may be denied from the SFD Program.

_____ _____

Patient Name (Print) **Date of Birth**

_____ _____

Signature (Patient/Parent/Guardian) **Date**

_____ _____

Witness Name and Signature **Date**