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Registration Form (Please Print)

Patient Information	***Email:***	
Patient's Last Name	**Patient's First Name**	**Middle:**

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

Date Of Birth: ___/___/_____ **Social Security Number:_____-____-_____**	**Sex:** **Male** **Female**	**Phone Number:**

Street Address/PO BOX:	**City**	**State**	**Zip**

Gender Identity:	**Male**	**Female**
Transgender Man	**Transgender Woman**	

Sexual Orientation:	**Lesbian/Gay**	**Straight/Heterosexual**
Bisexual	**Something else**	**Don't know**	**Choose not to disclose**

Insurance Information Do you have Insurance? □ **Yes** □ **No**
Interested in seeing our certified assistance counselor? □ **Yes** □ **No**
Please give your insurance card, Medicaid or Medicare Card to Receptionist

Primary Insurance:	Secondary Insurance:
Person Responsible for Bill: (address if different)	Date of Birth: ____/____/_____

In Case of Emergency

Name of Relative or Friend:	Relationship:	Home #: Work #:

Please select your race:	**Please select your ethnicity:**
□ Asian □ Native Hawaiian □ Other Pacific Islander □ Black/African American □ American Indian/Alaska Native □ White □ More than one Race □ Unknown/Refuse to report	□ Hispanic/Latino □ Not Hispanic/Latino □ Unknown/Refused to Report

Living status: □Homeless Shelter □Transitional □Doubling up □Street □Own/rent □ Unknown

Language: (If best served in other than English)	**Are you a Veteran? □ Yes □ No**

ASSIGNEMENT AND RELEASE, the undersigned, have insurance coverage with _____and assign directly to HOPE Community Medicine, and associated healthcare providers all medical payments and benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submission.

MEDICARE AUTHORIZATION request that payment of authorized Medicare benefits be made on my behalf to HOPE Community Medicine for any services furnished by their healthcare provider. I authorize the holder of medical information about me to release to the Health Care Financing Administration or appropriate agents, any information needed to determine these benefits payable to related services.

I understand my signature request that payments be made or authorizes the release of medical information necessary to pay the claim. If "the other health insurance" is indicated on the HCFA form or elsewhere on the approved claim forms of electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carries as the full charge, and the patient is responsible only for the deductible, coinsurance, and uncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier.

Patient/Guardian Signature _____Date _____

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Medication History Consent

This consent will enable us to:

- Determine the pharmacy benefits and drug co pays for a patient's health plan
- Check whether a prescribed medication is covered (in formulary) under the patient's plan
- Display therapeutic alternatives with preference rank (if available) within a drug class for medication.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

Also, I give permission for HOPE Community Medicine to access my pharmacy benefits data electronically through RxHub.

Consent for Health Information Search Engine (PRISMA)

PRISMA is the health information search engine that brings together records from small clinics to large-scale hospital systems whose EHR systems participate in the Carequality and CommonWell Health alliance networks. PRISMA also aggregates patient information from insurance payers and patients' wearable devices to promote better interoperability.

PRISMA lets providers:

Obtain patient records from providers and hospitals

Search the patient's complete record by using keywords or abbreviations to locate conditions, diagnoses, treatments, medications, and more

Better understand a patient's health history through an organized timeline view

I give my consent to:

◯ Send	◯ Receive	◯ Opt out

Do you have any of the following advanced Directives?

____Living Will

____DNR (Do Not Resuscitate) order

____Health Care Power of Attorney

In the event that a patient request assistance in the formulation of an advanced directive, the appropriate staff member will follow the states approved procedures to guide the individual to establish an advanced directive.

All questions contained in this form are strictly confidential & will become a part of your medical record.

I certify by my signature that I have provided all the information on any medical condition that I have been diagnosed or informed that I have.

_____ _____

Patient/Parent/Guardian Signature **Date**

General Consent for Treatment

Name of Patient: _____ **Date of Birth:** ____/____/____

Name of person giving consent if different from Patient:

[Print Name]: _____

Relationship to Patient: □ **Self** □ **Parent** □ **Guardian** □ **Other:** _____

I hereby and voluntarily consent to authorize HOPE Community Medicine's healthcare providers to provide health care services to me at HOPE Community Medicine's service location. The health care services may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical and/or dental treatment; routine laboratory procedures and tests; x-rays and other imaging studies; administration of medications; and procedures and treatments prescribed by HOPE Community Medicine's healthcare providers. The health care services also may include counseling necessary to receive appropriate services including family planning (as defined by federal laws and regulations).

I understand that I will be asked to sign a separate informed consent for vaccines to be administered to me and that I will receive a "Vaccine Information Statement" (VIS) prior to receiving each vaccine. I understand that there is a separate consent form that I may be asked to sign to be tested for infectious conditions.

I understand that there are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this.

I understand that this consent is valid and remains in effect as long as I am a patient of HOPE Community Medicine, until I withdraw my consent, or until HOPE Community Medicine changes its services and asks me to complete a new consent form.

Consent Provisions

My signature on this form indicates that:

1. I certify that I have read and fully understand the foregoing consent and that the facts indicated above are true.
2. I realize that although every effort will be made to keep all risks and side effects to a minimum, risks, side effects, and complications can be unpredictable both in nature and severity.
3. I understand that Nurse Practitioners, may be involved in my treatment and I consent thereto.
4. I understand that I may be asked to sign a separate informed consent form for certain Treatment(s) that require such.
5. I hereby voluntarily give my consent to Treatment at HOPE Community Medicine.

_____ _____

Signature of Patient/Legal Representative **Date/Time**

If signed by other than Patient, indicate relationship: _____

_____ _____

Witness Date

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Receipt of the Patient and
HOPE Community Medicine's Rights and Responsibilities

I, _____, have read, understood and received a copy of the patient and HOPE Community Medicine's Rights and Responsibilities.

If signing for a minor, _____
(Print minors Name)

_____
Patient/Parent/Legal Guardian Signature

_____ _____
Witness Date

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Acknowledgement of Receipt of Notice of Privacy Practices

In the course of providing services to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail.

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____

Relationship to Patient Print Name

Source of Authority: _____

I Authorize the Release of my Protected Health Information to the following individuals:

_____ _____

_____ _____

_____ _____

_____ _____

I acknowledge that I have received the Notice of Privacy Practices from The HOPE Project

_____ _____

Signature **Date**

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Patient Financial Policy

Payment is expected in full when services are rendered

Medicaid and / or Medicare:

Please provide us with your current Medicaid and / or Medicare card at each visit. If you have a co-pay, you will need to pay that amount at the time of service.

Private Insurance:

Please provide us with a copy of your insurance card at each visit. Payment for co-pays and deductibles will be due at the time of service.

Sliding Fee Discount/Self Pay:

Payment is due at the time of service. We accept cash, checks, Visa / Master card and debit cards. We offer a Sliding Fee Scale discount program based on income. To qualify, please provide proof of income at the time of your appointment. Please, refer to the front desk for any questions regarding our discount program.

Other Funded Programs:

We may offer other funded programs for which you may qualify. Please, refer to the front desk for additional information.

Thank you for choosing HOPE Community Medicine as your Medical and/or Dental provider. Please, let us know if you have any questions or concerns:

I acknowledge and accept the Patient Financial Policy.

_____ _____

Signature of Patient / Responsible Party Date

(For office use only)
Fees will be based on :

☐**Private Insurance** ☐**Medicaid** ☐**Medicare** ☐**Ineligible**

☐**Slide A** ☐ **Slide B** ☐ **Slide C** ☐ **Slide D** ☐ **Self-Pay**

*****Disclaimer: The Office Visit Fee does not include labs, procedures, or any other services.*****

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Sliding Fee Discount Refusal Form

Patient Name: _____

By signing below, the patient has declined to be assessed for eligibility for the sliding fee discount offered by HOPE Community Medicine.

The sliding fee discount refusal form will remain in effect for one (1) year. However, the patient may apply for the sliding fee discount at any time.

The sliding fee discount refusal will be scanned into the patient's electronic health record.

_____ _____

Patient/Patient Representative Signature Date

_____ _____

Witness Date