

Primary: _____ Dental: _____ Prenatal: _____

Patient Registration Form (2 pages)

New Annual

Home Location:

Families First

HH

Goodwin Community Health

Lilac City Pediatrics

PATIENT:

Name: _____ Date of Birth: ____/____/____ Gender (at time of birth): M F

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Okay to leave a voicemail? Yes No

Cell Phone: (____) _____ Okay to leave a voicemail? Yes No Okay to text you? Yes No

Email Address: _____ (Patient portal access available upon request)

Marital Status: Married Single Divorced Widowed

Ethnicity: Hispanic Non-Hispanic

Race: White Asian Native Hawaiian/Pacific Islander Black/African American American Indian More than one race Other _____

Veteran Status: Veteran Non-Veteran

U.S Citizen Yes No

Agricultural Work Status: Non-Agricultural Seasonal Migrant Employed year-round Retired Farmworker

Gender Identity: M F Female to Male Male to Female Genderqueer Other _____ Choose not to disclose

Preferred Pronouns: He/Him/His She/Her/Hers They/Their/Theirs Other _____

Sexual Orientation: Lesbian or Gay Straight Bisexual Something else _____ Don't know Choose not to disclose

Living Arrangements: Rent Own Stay w/relatives/friends Shelter Other temporary housing _____

Language: _____ Are you Deaf? Yes No *An interpreter can be provided during care upon request*

PARENT / GUARDIAN: (Complete if patient is under 18 years old)

1.) Name: _____ Date of Birth: ____/____/____ Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: Mother Father Other (please fill in): _____ Sex: M F

2.) Name: _____ Date of Birth: ____/____/____ Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: Mother Father Other (please fill in): _____ Sex: M F

EMERGENCY CONTACT: (In an emergent situation, the person listed below will be made aware that you are receiving care at our facility)

Name: _____ Relationship: _____ Phone: (____) _____

Preferred Local Hospital: _____ Ok to speak to regarding Medical Care Appointments

*COVERAGE MAY REQUIRE NOTIFYING THE INSURANCE CARRIER OF YOUR PROVIDER. THIS IS THE RESPONSIBILITY OF THE PATIENT. _____(Initials)

Primary Insurance Name: _____ Policy #: _____ Group #: _____

Subscriber's Name: _____ Subscriber's DOB: _____ Relationship to Patient: _____

Secondary/ Dental Insurance Name: _____ Policy #: _____ Group #: _____

Subscriber's Name: _____ Subscriber's DOB: _____ Relationship to Patient: _____

Employer providing insurance coverage: _____

1. How did you hear about us? _____ (New Patients only)

2. Are you transferring your care from another medical or dental office? Yes No If yes, where? _____

Patient / Guardian Signature: X _____ Date: _____ (OVER) -->

Please find your family size then follow that row across and **circle** the level closest to your **annual household income**. This helps us meet the requirements of the state and federal grants we receive.

Family Size	Between	Between	Between	Between	Over
1	\$0 - \$12,760	\$12,760 - \$17,609	\$17,609 - \$21,692	\$21,692 - \$25,520	\$25,520
2	\$0 - \$17,240	\$17,240 - \$23,791	\$23,791 - \$29,308	\$29,308 - \$34,480	\$34,480
3	\$0 - \$21,720	\$21,720 - \$29,974	\$29,974 - \$36,924	\$36,924 - \$43,440	\$43,440
4	\$0 - \$26,200	\$26,200 - \$36,156	\$36,156 - \$44,540	\$44,540 - \$52,400	\$52,400
5	\$0 - \$30,680	\$30,680 - \$42,338	\$42,338 - \$52,156	\$52,156 - \$61,360	\$61,360
6	\$0 - \$35,160	\$35,160 - \$48,521	\$48,521 - \$59,772	\$59,772 - \$70,320	\$70,320
7	\$0 - \$39,640	\$39,640 - \$54,703	\$54,703 - \$67,388	\$67,388 - \$79,280	\$79,280
8 +	\$0 - \$44,120	\$44,120 - \$60,885	\$60,885 - \$75,004	\$75,004 - \$88,240	\$88,240

SLIDING FEE DISCOUNT APPLICATION Greater Seacoast Community Health offers a discount based on income for patients who are uninsured, or whose insurance doesn't cover certain services (such as dental or behavioral health care).

To apply for the Sliding Fee Discount, please fill in the table below. Discounts are based on family size and household income. You must submit **proof of income** within 30 days from the date of service or the date on this form.

We will tell you what your sliding fee category and discount are, and you will be eligible for this discount for one year.

Examples of types of income:

- Social Security
- Business
- Alimony
- Child support
- Disability
- Others
- Retirement
- Welfare payments

Examples of proofs of income:

- 4 weeks of current and consecutive pay stubs
- Current tax return
- 4 weeks of **unemployment** check stubs

If applying for the Sliding Fee Discount, please provide the information below for yourself and all persons in your household.

Name (First, Middle Initial, Last)	Sex	Relationship to you	Date of Birth	Income & Frequency	Income Type
		SELF		\$	
				\$	
				\$	
				\$	
				\$	
Family Size:			Household Income:	\$	

The above information supplied is current and accurate to the best of my knowledge. I understand that if information provided is found to be inaccurate, any discount given may be reversed.

I **AM** applying for the Discount. I am **NOT** applying for Discount. Tell me about health insurance options available to me.

Patient/Guardian Signature **X** _____ Date: _____

OFFICE USE ONLY:

Approved Date: _____
 Usual Medical Fee: _____
 Basic Dental Payments: _____
 Major Dental Payments: _____

- | | | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Category 1 | <input type="checkbox"/> Category 2 | <input type="checkbox"/> Category 3 | <input type="checkbox"/> Category 4 | <input type="checkbox"/> Full Pay |
| <input type="checkbox"/> \$30 | <input type="checkbox"/> 40% | <input type="checkbox"/> 60% | <input type="checkbox"/> 80% | <input type="checkbox"/> Full Pay |
| <input type="checkbox"/> \$40 | <input type="checkbox"/> 50% | <input type="checkbox"/> 65% | <input type="checkbox"/> 80% | <input type="checkbox"/> Full Pay |
| <input type="checkbox"/> \$40+ | <input type="checkbox"/> 60% | <input type="checkbox"/> 75% | <input type="checkbox"/> 90% | <input type="checkbox"/> Full Pay |

Based on POI of \$ _____ monthly annually refused

Staff Name: _____ Date: _____

Reviewed by: Front Office Supervisor or Authorized Designee * Verification and Approval is reflected with initials, date and category directly on the income (subject to additional review).

Please PRINT the patient's name clearly: _____

**PLEASE READ CAREFULLY! SIGNATURES ARE REQUIRED BELOW BEFORE YOU MAY BECOME A PATIENT.
WE WILL ASK FOR YOUR SIGNATURE EVERY TWELVE MONTHS.**

The Foundation for Seacoast Health: Community Campus — Safe Campus Restrictions

In order to keep children and others on the community campus safe, our landlord, (The Foundation for Seacoast Health) will not allow on the Campus people who fall into the following categories:

- People who have been determined to be a sexual offender as defined by RSA 651-B,
- People who have been determined to be an offender against children as defined by RSA 651-B,
- Individuals who may pose a risk to the safety of others.

The Foundation for Seacoast Health is requiring that Families First take steps to make sure that people who fall into the above three categories are not coming to the Community Campus.

By signing this form, I agree to the following:

If Families First determines in its own judgment that I fall into any of the three categories listed above:

- I will be immediately discharged from Families First, and will not receive any more services;
- I will immediately leave the Community Campus and will not return;
- Families First will immediately release my name and address to the Foundation for Seacoast Health; and
- I will hold neither Families First nor the Foundations for Seacoast Health responsible for the release of my name and address to the Foundation for Seacoast Health.

The Foundation for Seacoast Health may prohibit me from coming to the Community Campus if it is determined that I fall into any of the three categories listed above.

Signature

Date

I hereby give permission for Families First Health Center to examine and conduct such referrals, tests and procedures as are needed for my diagnosis and care, and to give such treatment as the health center's providers deem necessary. I understand that Families First, medical and support staff, may disclose and use this information for treatment, including sharing this information with other providers to provide continuity of care.

I hereby authorize release of PHI (Personal Health Information) necessary to file a claim and audit with my insurance company and assign benefits to the provider or group indicated on the claim. I understand that I am financially responsible for any balance not covered by my insurance carrier, including, but not limited to, deductible and co-payments. At the end of sixty days, billing is my responsibility. A copy of this signature is valid as the original. The information I have provided is accurate and complete to the best of my ability.

Signature

Date

I acknowledge that I have read and understand the following documents: Health Center Patient Compact, Notice of Information Practices (Summary), Consent to Use and Disclose Health Information, "Safe Campus" Policy, Late Policy and **Health Insurance/PCP responsibility**. You may see these policies in Part II of the Patient Handbook, or on our website.

Signature

Date

If you have MEDICARE coverage you must sign below.

I request that payment of authorized Medicare benefits be made to Families First of the Greater Seacoast for services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services. (This payment authorization is to be completed, signed by the beneficiary and retained in the files of the provider of service. It is valid for any service Families First provides to the beneficiary during his/her lifetime, unless revoked.)

Print Name of Beneficiary: _____

Medicare # _____

Signature of Beneficiary or Representative: _____

Date: _____