Patient Registration

Do you need assistance filling out these forms? ☐ Yes ☐ No

PATIENT INFORMATION:

Last Name:_____**First Name**:_____**Middle Initial:** _____

Preferred Name:_____**Date of Birth**:_____**Social Security Number**: _____

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

Phone Number:_____**Email Address**: _____

Preferred contact method: □ Phone □ Text □ Email □ Other

Employer Name:_____**Phone Number**: _____

Emergency Contact:_____**Relationship**: _____ **Phone Number**: _____

Emergency Contact:_____**Relationship**: _____ **Phone Number**: _____

Marital Status: □ Single □ Married □ Divorced □ Partner □ Widow □ Legally Separated □ Declined to Specify

Birth Gender: □ M □ F

***Sexual Orientation**:

□ Straight
□ Gay/Lesbian
□ Bisexual
□ Don't know
□ Choose not to Disclose

***Gender Identity:**

□ Male
□ Female
□ Non-Binary
□ Transgender Male to Female
□ Transgender Female to Male
□ Other

***Preferred Language:**

□ English
□ Spanish
□ Other

***Do you need an interpreter?**

□ Yes
□ No

***Race**:

□ Alaska Native
□ American Indian
□ Asian
□ Black/African American
□ White
□ Native Hawaiian or Other Pacific Islander
□ Declined to Specify
□ Other Race

***Ethnicity**:

□ Hispanic/Latino
□ Not Hispanic/Latino
□ Declined to Specify
□ Refused to Report

***How did you hear about us?**

□ Social Media
□ Radio
□ Mail
□ Newspaper
□ Word of Mouth
□ Family/Friends
□ Staff Member
□ Other_____

***What is your annual household income?**_____**How many people live in your household?** _____

***What is your preferred pharmacy name?**_____**Phone Number:** _____

**The above information is requested by the Federal Government in order to monitor compliance with Federallaws prohibiting discrimination against users of HCC Network locations. You are not required to furnish this information but are encouraged to do so. This information will not be used to discriminate against you in any way, nor will be released except in aggregate form.*

INSURANCE INFORMATION:

Primary Medical Insurance: □ Medicare □ Medicaid □ Commercial □ Self-Pay

Name of Insurance:_____ **Policy Number**:_____ **Group Number:**_____

Subscriber's Name:_____ **Social Security Number:**_____ **Birthdate:**_____

Effective Date:_____ **Patient's relationship to Subscriber:** □ Self □ Spouse □ Child □ Stepchild □ Other

Secondary Medical Insurance: □ Medicare □ Medicaid □ Commercial □ Self-Pay

Name of Insurance:_____ **Policy Number**:_____ **Group Number:**_____

Subscriber's Name:_____ **Social Security Number:**_____ **Birthdate:**_____

Effective Date:_____ **Patient's relationship to Subscriber:** □ Self □ Spouse □ Child □ Stepchild □ Other

Primary Dental Insurance: □ Medicare □ Medicaid □ Commercial □ Self-Pay

Name of Insurance:_____ **Policy Number**:_____ **Group Number:**_____

Subscriber's Name:_____ **Social Security Number:**_____ **Birthdate:**_____

Effective Date:_____ **Patient's relationship to Subscriber:** □ Self □ Spouse □ Child □ Stepchild □ Other

Secondary Dental Insurance: □ Medicare □ Medicaid □ Commercial □ Self-Pay

Name of Insurance:_____ **Policy Number**:_____ **Group Number:**_____

Subscriber's Name:_____ **Social Security Number:**_____ **Birthdate:**_____

Effective Date:_____ **Patient's relationship to Subscriber:** □ Self □ Spouse □ Child □ Stepchild □ Other

PERSON (S) RESPONSIBLE FOR PAYMENT AND CARE:

□ Self □ Parent/Legal Guardian □ Detention Center □ Facility □ Durable Power of Attorney

Person Responsible for Payment:_____ **Phone Number:** _____

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

□ Self □ Parent/Legal Guardian □ Detention Center □ Facility □ Durable Power of Attorney

Person Responsible for Care:_____ **Phone Number:** _____

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

I hereby authorize payment directly to HCC Network for the medical, dental and/or behavioral health benefits for any services furnished to me or my dependents. I hereby authorize HCC Network to release any information acquired in the course of my examination or treatment necessary to establish a health insurance claim payment. I understand that occasionally my insurance company will deny payment for services that my physician and/orI feel necessary for my good health. Please note that self-pay/sliding scale patients may incur additional charges outside of self-pay office visit fees. I agree to pay for such services in a prompt and timely manner. I hereby authorize HCC Network providers to prescribe treatment, administer medications, and perform such proceduresand tests that may be deemed advisable or necessary in the diagnosis of me or my dependents. _____ **Initials**

SLIDE FEE SCALE:

Would you like to apply for HCC Network's Slide Fee Scale? □ Yes □ No

RELEASE OF INFORMATION:

I authorize HCC Network to release information to the following listed below:

Name:_____ **Relationship:**_____ **Phone Number:** _____

Name:_____ **Relationship:**_____ **Phone Number:** _____

Name:_____ **Relationship:**_____ **Phone Number:** _____

If I am unable to bring my child(ren) to an appointment, I authorize_____ to bring them.

RECORDS REQUEST:

For continuity of care, I authorize HCC Network to exchange records with my other healthcare providers:

□ Send & Receive □ Send Only □ Receive Only □ Opt Out ____**Initials**

Name:_____ **Specialty:**_____ **Phone Number:** _____

Name:_____ **Specialty:**_____ **Phone Number:** _____

Name:_____ **Specialty:**_____ **Phone Number:** _____

HIPAA NOTICE OF PRIVACY PRACTICES:

I acknowledge that HCC Network has made available to me the HIPAA notice of privacy practices. We are required by law to obtain your written acknowledgement that you are aware of this notice and have been provided an opportunity to obtain a copy. ____**Initials**

AUTHORIZATION TO PROVIDE MEDICAL AND HEALTH CARE SERVICES:

I hereby authorize HCC Network to provide medical examination services, immunological services, and routine medical/health services as considered normal and necessary; to secure and consent to medical,surgical, dental, and psychiatric care that is deemed necessary by a licensed physician, nurse, or mental health provider. ____**Initials**

APPOINTMENT POLICY:

I acknowledge that HCC Network has made available to me the Appointment Policy. ____**Initials**

TELEHEALTH CONSENT:

I acknowledge that HCC Network has made available to me the Telehealth Consent Form. ____**Initials**

HEALTH INFORMATION EXCHANGE PARTICIPATION:

I acknowledge that HCC Network has made available to me the Notice of Health Information Exchange Participation. ____**Initials**

Patient Signature:_____ **Date:**_____

Responsible Party Signature:_____ **Date:**_____

Responsible Party Name (Please Print): _____