



Patient Registration Form

Patient Information	Patient Information:			
	First Name:	Last Name:	M.I.:	First Name Used:
	Street Address:	Apt #	City:	State: Zip:
	Mailing Address: <input type="checkbox"/> Same as Street Address			Employment Status: <input type="checkbox"/> Student <input type="checkbox"/> Employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed
	Social Security #:	Date of Birth:	Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation:
	Home Phone: <input type="checkbox"/> None	Cell Phone: <input type="checkbox"/> Cell Phone is Home Phone		Work Phone:
	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow <input type="checkbox"/> Partner <input type="checkbox"/> N/A (pediatrics)			
	Patient/Guardian Email Address:		Preferred Pharmacy & Location:	
	Emergency Contact Name:	Emergency Contact Phone #:	Relationship to Patient:	
	Pediatric Patients Only: Please select and document the name of each person who is authorized to make medical decisions for the child (legal documents may be requested).			
	<input type="checkbox"/> Mother/Guardian:	Phone:	Patient/Guardian Email Address:	
	<input type="checkbox"/> Father/Guardian:	Phone:	Patient/Guardian Email Address:	
<input type="checkbox"/> Guardian or Foster Parent Name: <input type="checkbox"/> N/A		Foster Parent Agency: <input type="checkbox"/> N/A		
Mother's Maiden Name:				
Additional Patient Information	Additional Patient Information:			
	Preferred Language Patient Speaks: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Sign Language <input type="checkbox"/> Other: _____			
	Translation Assistance Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Race: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> White		Ethnicity: <input type="checkbox"/> Mexican, Mexican American, Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Another Hispanic, Latino/a, or Spanish <input type="checkbox"/> Non-Hispanic, Latino/a, or Spanish	
	Household Size & Income (For Children Enter Family Information): Number of People in the Household: _____ Income \$ _____ <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year <input type="checkbox"/> Choose Not to Disclose			
	Housing Status of Patient (Location Patient Slept Last Night): <input type="checkbox"/> At Home/Apartment <input type="checkbox"/> Group Home <input type="checkbox"/> Shelter <input type="checkbox"/> Car <input type="checkbox"/> Street <input type="checkbox"/> With a Friend/Relative			
Migratory/Seasonal Agricultural Work Status of Patient/Dependent: <input type="checkbox"/> Seasonal or <input type="checkbox"/> Migratory Worker <input type="checkbox"/> N/A/None/Neither				

Patient Name: _____ Date of Birth: _____

Insurance Information	Responsible Person Information - Person Who Is Responsible for Payment of Patient's Account:		
	First Name: <input type="checkbox"/> Same as Patient	Middle:	Last Name:
	Date of Birth:	Social Security #:	Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Home
	Address of Person Responsible: <input type="checkbox"/> Same as Patient		
	City/State/Zip:	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Guardian* <input type="checkbox"/> Custodial Parent <input type="checkbox"/> Foster Parent	
	Primary Medical Insurance		Dental Insurance
	<input type="checkbox"/> I Do Not Have Medical Insurance <input type="checkbox"/> I Would Like to Apply for a Reduced Fee <input type="checkbox"/> I Have Medical Insurance		<input type="checkbox"/> I Do Not Have Dental Insurance <input type="checkbox"/> I Would Like to Apply for a Reduced Fee <input type="checkbox"/> I Have Dental Insurance
	Insurance Company Name:		Insurance Company Name:
	Medical Policy #:		Dental Policy #:
	Billing Address of Insurance Company:		Billing Address of Insurance Company:
	Policy Holder's Name and Date of Birth:		Policy Holder's Name and Date of Birth:
	Policy Holder's Social Security #:		Policy Holder's Social Security #:
	<input type="checkbox"/> I Have Additional Medical Insurance , Name of Insurance:		<input type="checkbox"/> I Have Additional Dental Insurance , Name of Insurance:
	Medical Policy #:		Dental Policy #:
	Policy Holder's Name and Date of Birth:		Policy Holder's Name and Date of Birth:
Policy Holder's Social Security #:		Policy Holder's Social Security #:	
Patient Rights and Advance Directives	Patient Bill of Rights		
	<i>Would you like a copy of the Patient Bill of Rights:</i> <input type="checkbox"/> Yes, and a copy has been provided to me. <input type="checkbox"/> No, but I have been offered printed information and I have had the opportunity to ask questions.		
	Health Care Proxy		
	<i>A Health Care Proxy gives someone else the power to make medical decisions for you when you cannot speak for yourself. Do you have a Health Care Proxy?</i> <input type="checkbox"/> Yes, and a copy has been provided to North Country Family Health Center. <input type="checkbox"/> Yes, but a copy is not available at this time. <input type="checkbox"/> No, but I have been offered printed information related to a Health Care Proxy and I have had the opportunity to ask questions.		
Advance Directives			
<i>Advance Directives are written instructions relating to how healthcare is to be provided when and if an adult is unable to make their own decisions (examples of an Advance Directive: MOLST, DNR, Living Will, and/or Medical Power of Attorney). Do you have an Advance Directive?</i> <input type="checkbox"/> Yes, and a copy has been provided to North Country Family Health Center. <input type="checkbox"/> Yes, but a copy is not available at this time. <input type="checkbox"/> No, but I have been offered printed information related to Advance Directives and I have had the opportunity to ask questions.			

Patient Name: _____ Date of Birth: _____

North Country Family Health Center Policies and Consents

Permission to Disclose to Family or Other Individuals:

Adult Consent (Age 18 and Older): You may authorize North Country Family Health Center (NCFHC) to disclose your protected health information to family members or other individuals in order to assist with the coordination of your care.

No, I do not give NCFHC permission to disclose my protected health information to family members or other individuals in order to assist with the coordination of my care.

Yes, I give NCFHC permission to disclose my protected health information to the family members or other individuals listed below in order to assist with my coordination of care. This permission is valid for one year from the date of signature unless revoked or changed in writing prior to the expiration.

OR

Pediatric Consent (Age 17 or Younger): Non-Parental Consent: For pediatric patients, age 17 and under, you may designate another person to attend visits and authorize treatment decisions. Parents/legal guardians do not need to be added.

No, I do not give consent for another adult to attend, give consent, and make treatment decisions in my absence.

Yes, if I am unable to attend my child's appointments, I give consent for the following adult(s) to attend and to give consent for medical/dental/behavioral healthcare and to make treatment decisions for my child in my absence. I understand that when I designate another person to authorize a treatment decision, NCFHC may disclose protected health information to the authorized person(s).

If you checked "Yes" above, please complete the following section:

Name of Individual(s):	Relationship to Patient:

Finance Policy/Release of Billing Information/Assignment of Benefits: NCFHC serves all patients whether they are covered by insurance or not. When you use our services, you are responsible for the cost of those services. If you have insurance, you are responsible for understanding the limitations of your insurance coverage and are responsible for any co-pays, cost shares, and deductibles or non-covered services at the time service is provided. As a courtesy, we will bill your insurance for you. If requested, payment plans are available. We offer a sliding fee scale, which offers a discount on our services, to patients based on household size and income. You may apply for this Program at the front desk. We can also assist you with obtaining insurance coverage. I authorize NCFHC and its representatives to release any information they obtain, including medical information, to my insurance company or their representatives to process claims for payment. As applicable, I authorize my insurance provider to pay NCFHC for services rendered. I understand medical bills paid by credit card are no longer considered medical debt. By paying with a credit card, I am forgoing federal and state protections around medical debt which may include prohibitions on wage garnishment and property liens; prohibitions against reporting medical debt to credit bureaus; and limitations on interest rates.

Consent for Treatment:

- I authorize NCFHC to conduct any diagnostic or routine examinations, tests, and procedures to obtain specimens and to provide any medications, treatment, or therapy as necessary now or at future visits.
- I understand that specimens may be sent to an outside facility for processing. There may be a separate charge for this service.

Privacy Notice:

- I have been given the opportunity to review or receive a copy of NCFHC's Notice of Privacy Practices which describes how NCFHC may use and disclose my protected health information following applicable state and federal law. I understand NCFHC can request and use my prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.
- I understand that I have the right to receive a copy of my medical information or to request restrictions on the use of my protected health information.
- I understand that NCFHC may engage business associates to assist in my coordination of care including afterhours telephone and triage coverage and call reminder service. I understand these calls may be recorded to improve customer service and patient care.
- I understand NCFHC may use letters, reminder calls, text messages, or secure email correspondences to communicate with me regarding my care. I authorize NCFHC to communicate with me via these methods.
- I understand NCFHC may use computer assisted technologies guided by our internal policies and procedures to enhance my care, with all data processed securely and all clinical decisions made by a qualified healthcare provider.
- I understand my care team may include resident physicians, students, interns, or other trainees supervised by a NCFHC provider. I understand I have a right to refuse this arrangement at any time.
- I have been given the opportunity to review and receive a copy of NCFHC's Patient Responsibilities and understand that these responsibilities are posted in all NCFHC locations, online, and are physically available to me upon request. I understand that NCFHC maintains the right to discontinue treatment for any violation of these responsibilities. In such cases, the patient or parent/guardian agrees to accept full responsibility for pursuing alternate medical care.

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

Telehealth Consent:

NCFHC offers its patients telehealth services as a method to expand access to care. I understand I may be offered a telehealth appointment at NCFHC. I consent to receive services via NCFHC’s telehealth equipment or via my personal device and understand and/or agree to the following:

- I understand I have the right to refuse to participate in services delivered via telehealth at any time by informing any NCFHC staff member.
- I may request at any time an in-person appointment with another NCFHC healthcare provider.
- I understand that by selecting another provider there could be a delay in service and the potential need to travel for a face-to-face visit.
- I understand there are potential drawbacks of participating in a telehealth visit versus a face-to-face visit.
- I understand the healthcare provider performing the service will not be physically in the same room as me and will be performing the service at a different location, therefore, if parts of my care and treatment require physical examination they may be conducted by other NCFHC providers and staff under the direction of my telehealth healthcare provider or I may need to be re-scheduled for a face-to-face visit which could result in a delay in service and the potential need to travel for the face-to-face visit.
- I understand my visit will be conducted via technology and NCFHC cannot guarantee technology will always work.
- I understand that if there is an equipment failure I may need to be rescheduled for a face-to-face visit.
- I understand NCFHC utilizes HIPAA compliant, encrypted software to conduct its telehealth services.
- I understand I should use an internet service that is private and secure when using my personal device.
- I understand during the visit I should be in a private place, so other people cannot hear me.
- I understand I have the right to ask any questions regarding the telehealth equipment, technology, etc. at any time.
- I understand I will be informed and made aware of the role of the telehealth provider, if applicable, the role of the qualified professional staff at the NCFHC location who are going to be responsible for follow-up or ongoing care; and the location of the distant site if the provider is not located at a NCFHC site.
- I understand if I am attending a telehealth appointment at a NCFHC site, I have the right to have appropriately trained staff immediately available to me while receiving telehealth services to attend to emergencies or other needs. I understand this is not possible if I am conducting a telehealth visit from my place of residence located within the state of New York or other temporary location within or outside the state of New York.
- I understand I have the right to be informed of all parties who will be present at each end of the telehealth transmission and consent to have NCFHC staff in the exam room to operate telehealth equipment, if applicable.

New York State Immunization Information System (NYSIIS) Consent:

- I authorize NCFHC to release my immunization(s) and identifying information to NYSIIS; participation in NYSIIS for people 19 years of age and older is voluntary.
- I understand the purpose of NYSIIS is to assist in my medical care and to record the immunizations that I have had or will receive in the future.
- I understand my immunization information may potentially be used by the Department of Health for quality improvement purposes, epidemiologic research, and disease control purposes. Information used for quality improvement or any research purposes will have my personal identifying information removed.
- I understand the immunization information in NYSIIS may be released to the following: myself, my health insurance plan, the state and local health departments, the school that I am registered to attend, and authorized medical providers that deliver my medical care.

My Signature Means:

- I have reviewed and completed the Permission to Disclose to Family or Other Individuals section. I understand that when I designate another person to authorize a treatment decision, NCFHC may disclose protected health information to the authorized person(s).
- I have reviewed NCFHC’s Finance Policy/Release of Billing Information/Assignment of Benefits; Consent for Treatment; Privacy Notice; Telehealth Consent; and NYSIIS Consent.
- I have been given the opportunity to ask questions and all of my questions have been answered fully and satisfactorily.
- I understand that my consent will remain in effect for one year from the date of my signature unless I notify NCFHC in writing. I understand that I may revoke my consent at any time.

Printed Name of Patient/Legally Authorized Representative:	Relationship to Patient: <input type="checkbox"/> Patient <input type="checkbox"/> Relationship to Patient: _____
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Signature of Patient or Legally Authorized Representative:	Date:
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Witness to Signature if Legally Authorized Representative:	Date:
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