AllCare HEALTH CENTER

PATIENT REGISTRATION FORM

All information requested within this form is essential to ensure quality patient care or required by federal law. It will be kept private and confidential as a part of the patient's medical record.

SECTION I: PATIENT INFORMATION AND DEMOGRAPHICS

First Name: _____ Last Name: _____

Preferred Name: _____ Middle Initial: _____

Social Security Number (SSN): _____ Date of Birth (mm/dd/yyyy): _____

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

Preferred Language: _____ Interpreter Needed? ☐ Yes ☐ No

Please fill out any/all contact methods. Check box for preferred **contact method:**

☐ Preferred Phone: _____ ☐ Cell ☐ Home ☐ Work ☐ Other

☐ Alt. Phone: _____ ☐ Cell ☐ Home ☐ Work ☐ Other

Email Address: _____

Please check which of the following best describes your **sex assigned at birth:**

☐ Male ☐ Female

Please check which of the following best describes your **gender identity:**

☐ Male ☐ Female ☐ Transgender male/ female-to-male ☐ Transgender female/ male-to-female

☐ Choose not to disclose ☐ Don't know/Not applicable ☐ Non-Binary

Please check which of the following best describes your **sexual orientation:**

☐ Straight/heterosexual ☐ Lesbian, gay or homosexual ☐ Bisexual ☐ Something Else

☐ Choose not to disclose ☐ Don't know/Not applicable

Please check which of the following best describes your **preferred pronouns:**

☐ He, Him, His ☐ She, Her, Hers ☐ They, Them, Theirs ☐ Ze, Hir

☐ Decline to answer ☐ Unknown ☐ Other: _____

Please check which of the following best describes your **housing status:**

Are you homeless? ☐ Yes ☐ No

If yes, please describe your housing status:

☐ Homeless shelter ☐ Street homeless ☐ Transitional ☐ Permanent Supportive Housing

☐ Doubling Up ☐ Other homeless: _____

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Please answer the following questions:

Are you a veteran? ☐ Yes ☐ No

Are you a migrant farm worker? ☐ Yes ☐ No ☐ Seasonal

Are you attending school? ☐ Yes ☐ No

If yes, which school are you attending: _____

Please check which of the following best describes **your race.** Please only select

☐ American Indian or Native Alaskan ☐ Asian ☐ Black or African American ☐ Native Hawaiian

☐ Pacific Islander ☐ White ☐ More than one race ☐ Unknown, not listed, or refuse to report

Please check which of the following best describes **your ethnicity.** Please only select one:

☐ Hispanic, Latino, or Chicano ☐ Non-Hispanic, Latino, or Chicano ☐ Refuse to report

Please check which of the following best describes your primary medical coverage type. Please select only one:

☐ Medicaid ☐ Medicare ☐ Private or commercial insurance (including through Marketplace) ☐ None or uninsured

SECTION II: PATIENT HOUSEHOLD INFORMATION

Please **MARK** your family size and household income range (first find family size then find income range in same row)

Family Size:	Annual Income Ranges:					
1	☐ $0 - 12,880	☐ $12,881 - 16,100	☐ $16,101 - 19,320	☐ $19,321 - 22,540	☐ $22,541 - 25,760	☐ Over $25,760
2	☐ $0 - 17,420	☐ $17,421 - 21,775	☐ $21,776 - 26,130	☐ $26,131 - 30,485	☐ $30,486 - 34,840	☐ Over $34,840
3	☐ $0 - 21,960	☐ $21,961 - 27,450	☐ $27,451 - 32,940	☐ $32,941 - 38,430	☐ $38,431 - 43,920	☐ Over $43,920
4	☐ $0 - 26,500	☐ $26,501 - 33,125	☐ $33,126 - 39,750	☐ $39,751 - 46,375	☐ $46,376 - 53,000	☐ Over $53,000
5	☐ $0 - 31,040	☐ $31,041 - 38,800	☐ $38,801 - 46,560	☐ $46,561 - 54,320	☐ $54,321 - 62,080	☐ Over $62,080
6	☐ $0 - 35,580	☐ $35,581 - 44,475	☐ $44,476 - 53,370	☐ $53,371 - 62,265	☐ $62,266 - 71,160	☐ Over $71,160
7	☐ $0 - 40,120	☐ $40,121 - 50,150	☐ $50,151 - 60,180	☐ $60,181 - 70,210	☐ $70,211 - 80,240	☐ Over $80,240
8	☐ $0 - 44,660	☐ $44,661 - 55,825	☐ $55,826 - 66,990	☐ $66,991 - 78,155	☐ $78,156 - 89,320	☐ Over $89,320

SECTION III: INSURANCE INFORMATION

Insurance Name: _____ Policy number/Enrollment ID: _____

Group ID: _____ Member ID: _____

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SECTION IV: FINANCIAL RESPONSIBLE PARTY INFORMATION

First Name: _____ Last Name: _____

Preferred Name: _____ Middle Initial: _____

Social Security Number (SSN): _____ Date of Birth (mm/dd/yyyy): _____

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

Please fill out any/all contact methods. Check box for preferred contact method:

☐ Preferred Phone: _____ ☐ Cell ☐ Home ☐ Work ☐ Other

☐ Alt. Phone: _____ ☐ Cell ☐ Home ☐ Work ☐ Other

Email Address: _____

Preferred Language: _____ Interpreter Needed? ☐ Yes ☐ No

SECTION V: SHARE OF INFORMATION

I, _____, authorize All Care Health Center's medical and care coordination staff to discuss (share) health or medical information regarding my care with: _____

Patient Signature: _____ Today's Date: _____

SECTION VI: EMERGENCY CONTACT INFORMATION

Emergency Contact: _____

Relationship to Patient: _____ Phone Number: _____

How did you hear about All Care Health Center? _____

I authorize release of information regarding continuation of care and/or any payments for services. I authorize a copy of this document may be used as the original document. I certify all information provided is true and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

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CONSENT TO TREAT FORM

Consent to Routine Treatment

Patient First Name: _____ Patient Last Name: _____

Social Security Number (SSN): _____ Date of Birth (mm/dd/yyyy): _____

Please read and review each section and initial/sign where prompted.

1. Consent for Medical Treatment. I do hereby acknowledge, agree, and give my consent for diagnosis, treatment, behavioral health treatment, dental treatment of me/the patient as deemed necessary by All Care Health Center as indicated appropriate by treating provider, their assistants and/or designees (my "Consent"). I understand that I have the right to refuse treatment and that my signature below is not a consent to non-routine or non-emergent care. This Consent includes, but is not limited to, routine diagnostic procedures, outpatient and inpatient care, laboratory test, x-rays and other routine tests or procedures. In such routine cases, this Consent valid and shall apply to all repeat visits and continuing treatment and diagnosis for such conditions. In other cases, the treating practitioner may ask me to sign a form consenting to specific care, such as surgical procedures. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me/the patient as result to examination and treatment received at All Care Health Center. I acknowledge that my/the patient's care is under the direction of my/the patient's treating provider and the All Care Health Center facility will follow the instructions of my provider(s) in the position in said care.

2. Patient Care. I, the undersigned, agree to uphold my responsibilities to take charge of my/the patient's health care, working with my/the patient's provider and maintaining compliance with my/the patient's providers designated care plan for my/the patient's health and well-being.

3. Personal Valuables. I accept full responsibility for all property in my/the patient's possession. I understand that All Care Health Center maintains no responsibility for property that is personal and in my/the patient's possession.

4. Duration and Scope. I understand this Consent will be valid for one year (12 months) from the date it is signed, unless I revoke it sooner. This Consent will apply to any care provided to me/the patient at any All Care Health Center locations during the next year, unless the care provided requires additional consents by law.

5. Physician and Staff Employment. Some providers at All Care Health Center may be independent contractors who use All Care Health Center facilities to provide care to their patients ("Contractors"). As such, these various independent contractors may submit bills for the professional services they provide separate from the bill All Care Health Center may submit. This Consent extends to such Contractors. Contractors are responsible for their own actions and All Care Health Center Inc. is not liable for their actions or failure to act.

6. Assignment of Benefits. I hereby assign all insurance benefits and/or Medicare/ Medicaid benefits to All Care Health Center and its employees or others working under contract or arrangement with it and authorize direct payment to All Care Health Center. For Contractors billing separately from All Care Health Center, I assign coverage and benefits, and direct payment for their services provided to me, to such Contractors. This assignment includes all payments for charges incurred during treatment, visit and observation at all clinics for All Care Health Center and may not be revoked as to the services provided pursuant to this Consent. If there is an overpayment by me or by the insurance carrier, I direct the health center to apply the overpayment to any other unpaid account I/the patient may have with All Care Health Center. A photocopy of this agreement shall be as valid as the original.

7. Assignment of Medicare/Medigap.

Medicare: I request payment of authorized Medicare benefits on my/the patient's behalf for any services furnished to me/the patient by or in All Care Heallth Center. I authorize any holder of medical or other information about me/the patient to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. I certify that the information I have provided to All Care Health Center is true, accurate, and complete.

Medigap: I request that payment of authorized Medigap benefits be made on my/the patient's behalf to All Care

Health Center for any services furnished by it to me/the patient. I authorize any holder of medical information about me/the patient to release to my Medigap insurer any information needed to determine these benefits or the benefits payable for related services. Until revoked, this authorization applies to all occasions of service. This assignment is specific to the supplemental insurance information provided during registration (see scanned copy of the insurance card for policy number).

8. Authorized Representative. I hereby authorize All Care Health Center and its facilities, its agents and representatives to act on my/the patient's behalf to recover benefit claims, appeal adverse benefit determinations, and to take any action deemed necessary to obtain payment for services it provides to me/the patient.

9. Statement of Responsibility. I understand that I am financially responsible to All Care Health Center as the patient, guardian, and conservator or insured for all charges not covered by the above assignments or programs. Charges may include medical insurance deductibles, co-insurance out-of-pocket expenses. I agree to promptly and fully pay All Care Health Center for services and supplies provided to me/the patient at the rates now in effect or to become effective during the course of my care. I agree, subject to state or federal law, to pay all costs, reasonable attorney fees, expenses, delinquent charges and interest, in the event All Care Health Center has to take action to collect the same because of my failure to pay in full. I authorize All Care Health Center to obtain one or more credit reports on me/the patient. No extension or forbearance, no attempt to obtain payment from insurance or other sources and no delay or lack of diligence in collecting such charges shall waive or release the personal financial obligations hereunder.

10. Sliding Fee Discount Program Policy. All Care Health Center has a sliding fee discount program. There is an application process for sliding fee, and eligibility is based on family size, family income, and other special circumstances. I may request more information on the program or a sliding fee application at any time.

11. Self-Payment. I understand I may choose to not have All Care Health Center bill my/the patient's insurance for a particular health care item or service provided to me/the patient, and instead choose to personally pay in full the cost of that health care item or service. To exercise this option, I must notify All Care Health Center in a timely manner, complete additional forms, and pay all applicable charges promptly and in full.

12. Verification of Insurance Information; Release of Information to Insurance Company/Third Party Payer. I certify that the insurance information given by me is correct. I understand that it is my responsibility to notify All Care Health Center of any insurance coverage changes. All Care Health Center may release my/the patient's medical records to any person, corporation, workers compensation carrier, governmental agency (or representative thereof) which is or may be, liable for all or part of the charges.

13. Pre-Authorization; Non-covered Medicare/Medicaid Services. It is my responsibility to obtain any required pre-certifications or pre-authorizations and/or provide notification of admission as required by my/the patient[s insurance carrier. Not obtaining required certifications/authorizations may mean that my insurance carrier may not cover services that I/the patient receive. In such a case, I understand that I will be responsible personally for the cost of such services provided to me/the patient. The Medicare and Medicaid Programs have certain charges that are excluded from coverage, including but not limited to: cosmetic surgery, non-medically related dental surgery, routine diagnostic workups, routine physical exams, and oral drugs. All Care Health Center will notify me of anticipated non-coverage. If I agree to proceed with the care, I acknowledge I am financially responsible for all charges incurred.

14. Shadowing and Observation. Some people involved in my/the patient's care may be medical, nursing, or other health care personnel or students in training. I consent to their participation in my/the patient's care. I have the right to request that any of these individuals not participate in or observe my/the patient's care and this request will not affect my/the patient's care at All Care Health Center.

15. Contact by Phone. By providing All Care Health Center with my land line and/or cell phone number(s), I give my express consent for All Care Health Center, its contractors, agents, and collection agents to contact me at these numbers, or at any number that I later acquire, and to leave live or pre-recorded messages or to send text messages. The purposes of such contact may include appointment scheduling, education, telemarketing, debt collection, satisfaction surveys, or other purposes. I understand that for greater efficiency, calls may be delivered by an auto-dialer. If I discontinue use of any cell phone number I have provided, I will promptly notify All Care Health Center of the change. I hereby indemnify All Care Health Center and its agents and independent contractors from any expenses or other loss arising from my failure to notify All Care Health Center of the change.

16. Advanced Instructions for Healthcare. I understand that I/the patient may indicate in writing (Advanced Directions, i.e. Living Will and Durable Power of Attorney) the desire to receive, select, and/or define medical or surgical treatment or choose non-treatment All Care Health Center will recognize such instructions in accordance with applicable Iowa law and the Facility(s) policies if either both Advance Direction statement(s) are provided to the Facility(s) so that a copy is filed with any medical record.

17. Image and Audio Recording Consent. I agree that medical images, photographs, audio recordings and digital or video recordings may be made while I am/the patient is receiving care at All Care Health Center. I understand that the images and audio from such photography and recording may be used for my/the patient's treatment and these images and recordings will become part of my/the patient's medical information subject to uses and disclosures as described in the Notice of Privacy Practices.

18. Participation in HIEs. All Care Health Center participates in CyncHealth (a regional information exchange formerly known as NeHII), which was developed to share information so that participating health care providers can quickly view my health information when caring for me. By signing below, I acknowledge that I have been offered education about CyncHealth, and I understand that patient information will be included in CyncHealth unless I choose to opt out. I can request information on how to opt out.

_____ *Please Initial.* I acknowledge notification of All Care Health Center's Patient Rights and Responsibilities.

_____ *Please Initial.* I acknowledge receipt of All Care Health Center's Privacy Practices.

The undersigned certifies that he or she has read the foregoing, and all questions have been answered. The signee is the patient, patient's guardian, power of attorney, parent, or is duly authorized by or on behalf of the patient to execute the above and accept its terms.

Signature: _____ Date: _____

Name of Signee (if not patient): _____ Relationship: _____

Responsible Party's Signature *(if not the same as patient/parent):* _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Student Name: _____ **D.O.B.** _____
Parent/Legal Guardian Name: _____
Address: _____ **Phone:** _____

As the parent or legal guardian of a student receiving health care services from All Care Health Center, I hereby authorize All Care Health Center and any physician, nurse practitioner, medical assistant or other health care staff of All Care Health Center to furnish records and to discuss details of my student's care and treatment at All Care Health Center with staff (including, but not limited to, school nurses, counselors, teachers, therapists, administrators) at Council Bluffs Community School District (CBCSD). This authorization is to be ongoing until terminated. The purpose of the disclosure is to provide CBCSD staff with information about my student's health status, medications, treatments and clinic visits that they and the All Care Health Center staff believe is important for my student's safety and to promote the health and educational success of my student.

I understand and acknowledge that:

1. All Care Health Center may NOT condition my student's treatment, enrollment, or eligibility for benefits on whether I sign this Authorization.

2. Medical information that is disclosed because of this Authorization may be subject to re-disclosure by the recipient and no longer protected by State or federal law.

3. This authorization remains effective while my child is enrolled in the Council Bluffs Community School District. This authorization automatically expires when my student is no longer enrolled in the Council Bluffs Community School District.

4. I understand that I may revoke this Authorization at any time by giving written notice to All Care Health Center at the following address: 902 South 6th Street, Council Bluffs 51501

5. I understand that my revocation is not effective as to disclosures already made and actions already taken based upon this Authorization.

6. I have received a copy of this document.

A photocopy or exact reproduction of this signed Authorization shall have the same force and effect as the original.

_____ _____
Signature of Parent or Legal Guardian Date

COUNCIL BLUFFS COMMUNITY SCHOOL DISTRICT
Mobile Medical Services Enrollment and Consent Form

Student Information			
Student Last Name (legal):			Student Number:
First Name (legal):		Student Middle Name (full):	
Home Address:		City:	Zip:
Gender: ☐ M / ☐ F		Birth Date (mm/dd/yyyy): / /	
Grade:		Name of School Attending:	
Parent/Guardian			
Parent Last Name (legal):		Parent First Name (legal):	
Parent Middle Name (full):		Parent Birthdate (mm/dd/yyyy):	
Parent/Legal Guardian: ☐ Yes ☐ No		Relationship to Student:	
Home Phone:	Work Phone:		Cell Phone:
Email:		May we text your cell phone number? ☐ No ☐ Yes	
Second Parent/Guardian			
Parent Last Name (legal):		Parent First Name (legal):	
Parent Middle Name (full):		Parent Birthdate (mm/dd/yyyy):	
Parent/Legal Guardian: ☐ Yes ☐ No		Relationship to Student:	
Home Phone:	Work Phone:		Cell Phone:
Email:		May we text your cell phone number? ☐ No ☐ Yes	

Mobile Medical Services

Mobile medical services will be available at your child's school or a nearby school. These services will be provided by All Care Health Center (ACHC) in a mobile medical unit. The school nurse will coordinate care with ACHC once your child is enrolled. ACHC will also coordinate care with your child's primary care provider, dentist, and other health care providers, as appropriate to your child's care.

If you have private health insurance or Medicaid, ACHC providers will bill your insurance carrier for services provided. If you do not have health insurance, the ACHC will assist families with enrollment in Medicaid, if eligible.

Mobile medical services include the ability to screen health status, test for, diagnose and treat common conditions, e.g., sore throats, minor injuries, headaches, immunizations, ear infections, and diseases such as hepatitis, tuberculosis and sexually transmitted infections. Iowa law allows minors to consent to medical care and services for the prevention, diagnosis and treatment of sexually transmitted infections. Iowa law also allows minors to consent to voluntary contraceptive services. ACHC may provide behavioral and/or psychiatric services which includes the use of telehealth technology. Mobile Medical services do not include emergency services.

To allow CBCSD and ACHC staff to share confidential information for diagnosis and treatment purposes, a signed consent form must be on file with CBCSD and ACHC. ACHC staff will attempt to contact you regarding your child's visit and services provided.

By signing this enrollment and consent form, you consent to the following:

- I authorize All Care Health Center to examine and treat my child when mobile medical services are available at the school, and I understand that no guarantee has been made as to the results of such examinations and treatments. I understand that for certain services described above, my minor child may consent to such service on his or her own, in accordance with applicable law.
- I authorize CBCSD staff, including the school nurse, to release the following student information to the ACHC so that they can provide services and conduct program evaluation: family and emergency contact information, state student number, attendance and disciplinary records, schedule, immunization history, results of health screenings such as hearing and vision, psychological evaluations, special education (IEP-MDT) records, Section 504 Accommodation Plan, and information regarding any health condition, such as seizures, allergies, concussions or asthma.

This authorization expires when my child leaves CBCSD or graduates. I understand that I may revoke this authorization at any time by giving notice to the Council Bluffs Community School District at 712-328-6493 x13170.

Mobile Medical Services ☐ **No** **Yes** I authorize AllCare Health Center to examine and treat my child as described above. I further authorize CBCSD to release information as described above.

Parent/Guardian Signature	Relationship to Child	Date