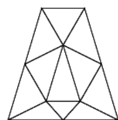


AllCare
HEALTH CENTER

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: ______________

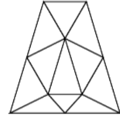
Please check which of the following best describes your **housing status:**

Are you homeless? ☐ Yes ☐ No

If yes, please describe your housing status:

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

☐ Doubling Up ☐ Other homeless:______



PATIENT REGISTRATION FORM

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

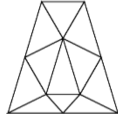
Please **MARK** your family size and household income range (first find family size then find income range in same row)

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: ______________________________



PATIENT REGISTRATION FORM

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

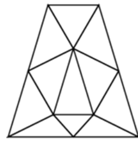
Emergency Contact: ________________________

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: __________



SLIDING FEE APPLICATION

Proof of Household Income to include one of the following: most recent 30 days of consecutive pay stubs, prior year tax return, current Social Security/disability benefits, Proof of income from the social security office or Workforce office.

PATIENT INFORMATION:

Patient's Name: ____ Date of Birth: ______________________

Address: ____

Telephone Number: (_____) ______________________

Others in household - please complete for everyone living in your household:

Name	Relationship	Date of Birth

Total number in household: _____________________

HOUSEHOLD INCOME VERIFICATION: ____ I do not wish to disclose my income. I am not interested in receiving any discounts.

Employed ______ Unemployed ______ Disability ______ Other _____________

Place of employment: ____

Yearly Gross Income (before taxes): $______________________ Monthly Gross Income: $______________________

PATIENT AGREEMENT: *By signing this form, I agree that all information given is a complete and accurate statement to the best of my knowledge. I authorize All Care Health Center (ACHC) to check all information presented. I agree to report any changes in income, change of insurance coverage, or household size to ACHC immediately. I understand that any person who obtains or attempts to obtain by illegal means, services to which he/she is not entitled, may be charged under the applicable state and federal statutes. I authorize permission for Program designees to review my records for auditing purposes:*

****By signing below, I agree to bring in proof of income within 30 days to receive any discount for which I am eligible.**

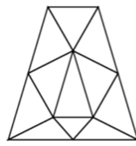
Signature of Applicant: ____ Date: _________________________

Signature of Intake Representative: ____ Date: _________________________

OFFICE USE ONLY

Annual Household Income: ________________ Date Verified _________ Poverty %: _________ Slide scale: ______

Updated 7/12/19



Documents to bring as proof of income for the Sliding fee Scale

Choose 1 from the options listed below

You have 30 days from the application date to provide the proof of income

Documents accepted as proof of income (POI):

Employment wages

*2 most recent if paid **biweekly** (30 days of consecutive paystubs)
*4 most recent if paid ***weekly*** (30 days of consecutive paystubs)
*2 most recent if paid ***monthly*** (60 days of consecutive paystubs)

Social Security wages (Social Security Administration Monthly benefit letter dated with most recent calendar year, NO 1099 FORMS)

Social Security Disability (Social Security Administration Monthly benefit letter dated with most recent calendar year, NO 1099 FORMS)

Prior year tax return (This is good until April 15 of current year, NO W2s)

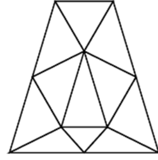
Current year tax return (NO W2s)

Proof of income from the Social Security office (Social Security Earnings Record)

Unemployment (Unemployment Benefit Statement must be dated within the last 3 months)

If you do not have any of these documents, please contact our *Patient Financial Advocate* at 712-256-6589 to discuss other documents determined on an individual basis and at the discretion of management.

Updated 07/12/19



AllCare
HEALTH CENTER

Patient Rights and Responsibilities

It is the policy of All Care Health Center to treat all patients and not to discriminate with regard to race, color, religion, national origin, age, sex, sexual orientation, gender identity or expression, or disability.

Each patient has a right to

- High quality health care from clinicians who are experienced and trained to meet your medical, dental, and/or mental healthneeds.
- Considerate and safe care that respects your social, religious and cultural values.
- A reasonable response to your requests for treatment.
- Confidential treatment.
- Full information about your medical condition.
- Information compiled in your medical record.
- Participate in decisions about your treatment.
- Accept or refuse treatment.
- Be informed of advance directives and receive assistance with their formulation.
- Be informed of any research that could affect your care.
- Be informed and consent in writing to diagnostic procedures performed by our staff.
- Receive appropriate, clinically approved methods to alleviate pain when those methods are available, necessary and meet your health needs.
- Know the professional experience and certification of our medical providers, our JCAHO accreditation status and other measures of quality.
- Affordable health care and information about the cost of procedures.
- Information about the health plans used by All Care Health Center.
- Influence the operation of All Care Health Center through a board of directors who represent the communities we serve.
- A fair and efficient process for resolving differences with us and to be informed of the grievance procedures used by health plans in which we participate.
- Your guardian, next of kin, or legally authorized responsible person can exercise your rights for you if you are unable to participate.

Patient Responsibilities

- Disclose relevant information and clearly communicate wants and needs.
- Become involved in specific health care decisions.
- Work collaboratively with health care providers in developing and carrying out agreed-upon treatment plans.
- Avoid knowingly spreading disease.
- Show respect for other patients and health care workers.
- Avoid eating, drinking, or taking photos or videos in the health center.
- Disclose financial information and pay for services responsibly.
- Abide by administrative and operational procedures of health plans, health care providers and government health benefit programs.
- Report wrongdoing and fraud to appropriate authorities.
- Use All Care Health Center’s internal complaint and appeal processes to address concerns that may arise.
- Formally consent to treatment by signing an annual Consent to Treat statement.

Updated: 03/13/2019