FCHC Medical Care - PATIENT REGISTRATION FORM

PLEASE COMPLETE IN BLACK INK

TODAY'S DATE

LAST NAME	LEGAL FIRST NAME	MI	PREFERRED NAME if different than Legal Name
MAILING ADDRESS	CITY	STATE	ZIP
SOCIAL SECURITY NUMBER	DATE OF BIRTH	MARITAL STATUS	EMAIL ADDRESS

FCHC Medical Care, LLC is asking you to complete the next section to meet the requirements of Section 1557 of the Affordable Care Act. This is not specific to FCHC Medical Care, LLC, all healthcare facilities must comply.

LEGAL SEX:
❒ Female
❒ Male

WHAT IS YOUR GENDER IDENTITY?
❒ Female
❒ Male
❒ Trans Male (Female to Male)
❒ Trans Female (Male to Female)
❒ Other
❒ Decline to Answer

WHAT IS YOUR SEXUAL ORIENTATION?
❒ Bisexual
❒ Heterosexual or Straight
❒ Lesbian, Gay or Homosexual
❒ Something Else
❒ Decline to Answer
❒ Don't Know

PREFERRED FORM OF COMMUNICATION FOR APPOINTMENT REMINDERS? ❒ Home Phone ❒ Cell Phone ❒ Text Message

PREFERRED TIME TO CALL FOR APPOINTMENT REMINDERS? ❒ Morning ❒ Afternoon ❒ Evening

PHONE: HOME	MAY WE CONTACT YOU AT HOME? MAY WE LEAVE A DETAILED MESSAGE?	YES YES	NO NO
PHONE: CELL	MAY WE CONTACT YOU ON YOUR CELL PHONE? MAY WE LEAVE A DETAILED MESSAGE?	YES YES	NO NO
PHONE: WORK	MAY WE CONTACT YOU AT WORK? MAY WE LEAVE A NAME & CALL BACK NUMBER?	YES YES	NO NO

WHOM WE ARE ALLOWED TO DISCUSS AND/OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION?

Information in your medical record is confidential and is protected under HIPAA/Ohio Laws. By completing this section and signing the Patient Registration Form consent, you are allowing our office to disclose your protected health information with the following:

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE

ETHNICITY (PLEASE CHECK ONE OF THE FOLLOWING)
❑ HISPANIC OR LATINO
❑ NOT HISPANIC OR LATINO
❑ DECLINE TO ANSWER

RACE (PLEASE CHECK ALL THAT APPLY)
❑ AMERICAN INDIAN OR ALASKA NATIVE
❑ BLACK OR AFRICAN AMERICAN
❑ OTHER PACIFIC ISLANDER
❑ DECLINE TO ANSWER
❑ ASIAN
❑ HISPANIC
❑ NATIVE HAWAIIAN
❑ WHITE

PRIMARY LANGUAGE
❑ ENGLISH
❑ SPANISH
❑ ASL
❑ OTHER

EMPLOYER NAME		OCCUPATION	
EMPLOYER ADDRESS	CITY	STATE	ZIP

IF PATIENT IS MARRIED PLEASE COMPLETE THE FOLLOWING INFORMATION

SPOUSE'S INFORMATION

LAST NAME	LEGAL FIRST NAME	MI	PHONE NUMBER
MAILING ADDRESS	CITY	STATE	ZIP
SS#	DATE OF BIRTH	OCCUPATION	
EMPLOYER NAME	EMPLOYER ADDRESS		

IF PATIENT IS A MINOR CHILD PLEASE COMPLETE THE FOLLOWING INFORMATION

PARENT/GUARDIAN'S INFORMATION

LAST NAME	LEGAL FIRST NAME	MI	PHONE NUMBER
MAILING ADDRESS	CITY	STATE	ZIP
SS#	DATE OF BIRTH	OCCUPATION/	
EMPLOYER NAME	EMPLOYER ADDRESS		

PARENT/GUARDIAN'S INFORMATION

LAST NAME	LEGAL FIRST NAME	MI	PHONE NUMBER
MAILING ADDRESS	CITY	STATE	ZIP
SS#	DATE OF BIRTH	OCCUPATION	
EMPLOYER NAME	EMPLOYER ADDRESS		

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TODAY'S DATE

LAST NAME	LEGAL FIRST NAME	MI	

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE NUMBER

MAILING ADDRESS	CITY	STATE	ZIP

PRIMARY CARE PROVIDER/PHYSICIAN

NAME	PHONE NUMBER

ADDRESS	CITY	STATE	ZIP

PREFERRED PHARMACY

NAME	PHONE NUMBER

ADDRESS	CITY	STATE	ZIP

IT IS THE PATIENT/GUARANTOR'S RESPONSIBILITY TO COMPLETE THE INSURANCE INFORMATION BELOW AND TO PROVIDE INSURANCE CARD(S) SO FCHC MEDICAL CARE, LCC CAN BILL YOUR INSURANCE APPROPRIATELY.

PRIMARY INSURANCE COVERAGE – IF NO COVERAGE, PLEASE CHECK HERE ❑

INSURANCE COMPANY NAME	GROUP NAME (EMPLOYER)

I.D. NUMBER	GROUP NUMBER

POLICY HOLDER NAME	RELATIONSHIP

POLICY HOLDER'S SOCIAL SECURITY NUMBER	POLICY HOLDER'S DATE OF BIRTH

INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP

INSURANCE COMPANY PHONE NUMBER	EFFECTIVE DATE	PRESCRIPTION CARD? YES NO	COPAY

SECONDARY INSURANCE COVERAGE

INSURANCE COMPANY NAME	GROUP NAME (EMPLOYER)

I.D. NUMBER	GROUP NUMBER

POLICY HOLDER NAME	RELATIONSHIP

POLICY HOLDER'S SOCIAL SECURITY NUMBER	POLICY HOLDER'S DATE OF BIRTH

INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP

INSURANCE COMPANY PHONE NUMBER	EFFECTIVE DATE	PRESCRIPTION CARD? YES NO	COPAY

CONSENT TO RELEASE MEDICAL INFORMATION/ASSIGNMENT OF BENEFITS

I hereby consent to the use and disclosure by FCHC Medical Care, LLC of medical information to carry out medical treatment. Payment and health care operations as defined by applicable law. MEDICAL TREATMENT includes the provision, coordination and management of my health care and related services, including treatment by other health services and/or their agents to whom I may be referred (and any referring and primary care/family physician which have been or may be involved in my care and treatment). PAYMENT includes all activities relating to the determination of coverage and reimbursement for the provision of health care services and related claims management and review activities. HEALTH CARE OPERATIONS include activities of FCHC Medical Care, LLC relating to medical care and treatment and related assessment, quality improvement and management activities.

I authorize the disclosure of my clinical health information for the duration of my care unless revoked in writing to those listed under **WHOM WE ARE ALLOWED TO DISCUSS AND/OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION?**

I authorize my insurance benefit to be paid directly to FCHC Medical Care, LLC realizing that I am ultimately responsible for any allowable portion of the charge not covered by my insurance plans.

PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE	DATE
X	

If signed by patient's authorized representative, describe representative's authority:

□ Patient is a minor; I am the patient's parent and natural guardian.

□ Patient is a minor; I am the patient's guardian, appointed by the _____ County Juvenile Court.

□ Patient is a ward; I am the patient's guardian, appointed by the _____ County Probate Court.

□ I am the patient's attorney in fact, as designated in the patient's durable power of attorney for health care.

WITNESS SIGNATURE	DATE