



## Registration Form

New Patient

Established Patient

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Other/Maiden/AKA Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell or Work Phone: \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Race: Caucasian (White) \_\_\_\_\_ Afro-American (Black) \_\_\_\_\_ American Indian/Alaska Native \_\_\_\_\_ Asian \_\_\_\_\_  
Native Hawaiian \_\_\_\_\_ Pacific Islander (other than Hawaiian) \_\_\_\_\_ Whites of Latino/Hispanic descent \_\_\_\_\_  
Blacks of Latino/Hispanic descent \_\_\_\_\_ American Indian of Latino/Hispanic Descent \_\_\_\_\_ More than One Race \_\_\_\_\_  
Refuse to Report \_\_\_\_\_

Are you a veteran of the United States Armed Forces?  Yes  No

### Responsible Party

Name: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Birthdate: \_\_\_\_\_

### Insurance Information

Do you have insurance?  Yes  No

If Yes, please specify:  Medicare  Medicaid  CHIP  Private Insurance

Primary Insurance Company \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_

**SEE OTHER SIDE**

**Siding Fee Discount For Service**

I understand that in order to receive the federal sliding fee discount for services received at Southwest Utah Community Health Center, I am required to provide proof of income for all wage earners in my household. I understand that all sources of income, including wages, unemployment, social security, retirement, alimony, child support and disability income will be included. I understand that verification of income is required and can include check stubs, letters from employers, and copies of income tax information and/or documents from government services. **I understand that my family will be charged full fee for services until proof of income is provided.**

I understand that proof of income allows me to receive discounted services. I know that I will pay a co-pay for each visit and may be charged more depending on the services received.

I understand that if I have insurance, the Community Health Center may be able to discount deductibles and co-insurance with proof of income.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**PAYMENT IS DUE AT THE TIME OF SERVICE. PLEASE READ AND SIGN THE FOLLOWING:**

VERIFICATION OF INCOME REQUIRED TO RECEIVE CARE AT A REDUCED RATE \_\_\_\_\_ (Initial)

I understand that in order to qualify to receive medical care at a reduced rate, I must provide verification of income. If I do not provide verification of income now, I must bring my income verification to Southwest Utah Community Health Center within 7 days. I also understand that my eligibility to receive medical care at a reduced rate will be reviewed every 6 months.

FINANCIAL AGREEMENT AND RELEASE OF INFORMATION \_\_\_\_\_ (Initial)

I authorize Southwest Utah Community Health Center to bill my insurance carrier for services rendered. I also authorize Southwest Utah Community Health Center to release all or part of the patient’s record to any person or organization liable for payment. I permit a copy of this authorization to be used in place of the original release of information form and request that the payment of medical insurance benefits be paid to Southwest Utah Community Health Center. **I agree to pay for all charges not paid by my insurance company. If my account is sent to a collection agency, I agree to pay all reasonable collection and attorney’s fees.**

RIGHTS AND RESPONSIBILITIES AND NOTICE OF PRIVACY PRACTICES \_\_\_\_\_ (Initial)

I have been advised of my rights and responsibilities as a patient of Southwest Utah Community Health Center. I have received a copy of the Patient’s Bill of Rights and Responsibilities and a copy of the Notice of Privacy Practices.

CONSENT FOR TREATMENT \_\_\_\_\_ (Initial)

I authorize the Southwest Utah Community Health Center physician or mid-level provider to perform such diagnostic, medical, and/or surgical procedures as may be necessary for proper health care. I also give permission for administration of medications and immunizations as may be necessary for that treatment.

I have read all of the information on this registration form and have completed it to the best of my ability. I certify that this information is true and correct to the best of my knowledge. I understand that verification of the above information may be required at any time for any reason. If found ineligible, I may be subject to immediate termination of services and/or prosecution for fraud/perjury. I WILL NOTIFY SOUTHWEST UTAH COMMUNITY HEALTH CENTER OF ANY CHANGES IN MY HEALTH STATUS OR ANY OF THE ABOVE INFORMATION.

\_\_\_\_\_  
Patient’s Signature (If a minor, signature of responsible party)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

Witnessed By: \_\_\_\_\_

Date: \_\_\_\_\_