RVPCS Patient Registration Form *Updated 07/2018 Demographics*

As a Federally Qualified Health Center, River Valley Primary Care Services is required to collect demographic information regarding the patients we serve. The information you provide is confidential.

Section 1: Patient Information

First Name: _____ **Middle Name:** _____ **Last Name**:_____

Suffix: _____ **Social Security Number**: _____ **Sex**: ☐ Male ☐ Female

Date of Birth: _____ **Marital Status**: ☐ Single ☐ Married ☐ Other: _____

Mailing Address: _____ **City:** _____

State: ____ **Zip Code**: _____ **Email:** _____ **Primary Phone:** ☐ Home ☐ Cell ☐ Work

Home Phone: _____ **Cell Phone:**_____ **Work Phone**: _____

Preferred Communication: ☐ No Preference ☐ Phone ☐Mail ☐MyChart (Patient Portal, please provide an email)

Special Needs? ☐ None ☐ Glasses ☐ Hearing Aids ☐ Other _____ ☐ Patient Refused Disabled**?** ☐ Y ☐ N

Employment Status: ☐ Full Time ☐ Part-Time ☐ Self ☐ Retired ☐ Not Employed

Employer: _____

Student Status: ☐ Full Time ☐ Part-Time ☐ Not in school

1. **Pharmacy Name:** _____ **City**: _____ **Mail Order:** ☐ Y ☐ N
2. **Pharmacy Name:** _____ **City**: _____ **Mail Order:** ☐ Y ☐ N

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____ Interpreter Needed? ☐ Y ☐ N

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ African American ☐ Caucasian ☐ Native Hawaiian/Other Pacific Islander ☐ Not Reported/ Refused ☐ Other: _____

Ethnicity: ☐ Latino/Hispanic ☐ Non-Latino/Hispanic ☐ Not Reported/Refused

Gender Identity: ☐ Not Reported/Refused ☐ Female ☐ Male ☐ Transgender Female (Male-to-Female)

☐ Transgender Male (Female-to-Male) ☐ Non-Binary (Identifying as any other gender than female or male)

☐ Uncertain ☐ Other: _____

Sexual Orientation: ☐ Not Reported/Refused ☐ Heterosexual/Straight ☐ Homosexual/Gay/Lesbian

☐ Bisexual ☐ Uncertain ☐ Other: _____

*RVPCS is a federally funded organization and therefore is required to ask our patients their sexual orientation as well as their gender identity in order to identify and reduce health disparities as well as promote culturally competent care. If you do not wish to disclose this information, please mark "Not Reported/Refused"

Section 2: Guarantor (Financially Responsible Individual) Information

Guarantor is: ☐ Patient (no need to complete the rest of this section) ☐ Person ☐ Company

Patient's relationship to Guarantor: ☐ Child ☐ Parent ☐ Spouse ☐ Employer ☐ Other: _____

First Name: _____ **Middle Name:** _____ **Last Name**:_____

Suffix: _____ **Social Security Number**:_____ **Sex**: ☐ Male ☐ Female

Date of Birth: _____ **Marital Status**: ☐ Single ☐ Married ☐ Other: _____

Street Address: _____ **City:** _____

State: ____ **Zip Code**: _____ **Email:** _____ **Primary Phone:** ☐ Home ☐ Cell ☐ Work

Home Phone: _____ **Cell Phone:**_____ **Work Phone**: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____ Interpreter Needed? ☐ Y ☐ N

Section 3: Family Income and Shelter Information

RVPCS is a federally funded organization and therefore is required to ask our patients about their family income for reporting.

If you are in need of financial assistance, please ask for our Sliding Fee Application.

Please indicate your family annual income (required information for federal reporting)

How many persons are in the household? _____

____$0-$5,000 ____$5,000-$10,000 ____$10,000-$20,000 ____$20,000-$30,000 ____$30,000-$40,000

____$40,000-$50,000 ____$50,000-$60,000 ____$60,000-$70,000 ____$70,000-$80,000 ____$80,000-$90,000

____$90,000+ ____ Do not wish to Disclose/Unknown

Homeless Status: ☐ Not Homeless ☐ Homeless shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Other _____

Worker Status: ☐ Migrant ☐ Not Migrant ☐ Seasonal **Veteran:** ☐ Yes ☐ No

Section 4: Patient Insurance Information

Please allow our staff to copy your insurance card(s)

Primary Insurance Information

Insurance Company/Plan Name: _____

Member ID:_____ **Group Number:** _____

☐ **Use Patient Information** (No need to complete the rest of this section)

Patient's Relation to Holder: ☐ Child ☐ Parent ☐ Spouse ☐ Other: _____

First Name: _____ **Middle Name:** _____ **Last Name**:_____

Suffix: _____ **Social Security Number**:_____ **Sex**: ☐ Male ☐ Female

Date of Birth: _____ **Street Address:** _____

City: _____ **State:** _____ **Zip Code**: _____ **Phone:** _____

Secondary Insurance Information

Insurance Company/Plan Name: _____

Member ID:_____ **Group Number:** _____

☐ **Use Patient Information** (No need to complete the rest of this section)

Patient's Relation to Holder: ☐ Child ☐ Parent ☐ Spouse ☐ Other: _____

First Name: _____ **Middle Name:** _____ **Last Name**:_____

Suffix: _____ **Social Security Number**:_____ **Sex**: ☐ Male ☐ Female

Date of Birth: _____ **Street Address:** _____

City: _____ **State:** _____ **Zip Code**: _____ **Phone:** _____

Section 5: Emergency Contact & HIPAA Information

Name:_____Relationship_____Phone_____**Authorized HIPAA:** ☐ Yes ☐ No

Name:_____Relationship_____Phone_____**Authorized HIPAA:** ☐ Yes ☐ No

Name:_____Relationship_____Phone_____**Authorized HIPAA:** ☐ Yes ☐ No

Name:_____Relationship_____Phone_____**Authorized HIPAA:** ☐ Yes ☐ No

Name:_____Relationship_____Phone_____**Authorized HIPAA:** ☐ Yes ☐ No

By signing this form, I [the patient/guardian] authorize RVPCS to use and/or disclose PHI to the contacts checked YES for authorized HIPAA. RVPCS may contact you with appointment and medical information through phone, mail, MyChart, or with your Authorized HIPPA appointed contact.

Patient Name: _____ Date of Birth: _____

Patient/Guardian Signature: _____ Today's Date: _____

Section 6: Consent to Treatment and Payment Authorization

You are responsible for your own bill.*

As a courtesy, RVPCS will submit charges to your insurance carrier.

Understand that you are financially responsible for all charges incurred whether or not you have insurance.

- I hereby assign, transfer, and set over to RVPCS all of my rights, title, and interest to my medical reimbursement benefit under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I, revoking said authorization, give written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.*

- I authorize consent to outpatient care which may encompass examination and medical or dental treatment, routine diagnostic procedures including [but not limited to] laboratory studies, dental x-rays, electrocardiogram [EKG], and administration of medications as ordered by the physician or dentist. [Dental treatment at Ratcliff only.]

- I further authorize the release of pertinent medical and treatment documentation to other physicians involved in by care through referral or shared care.

- I, the undersigned, understand that a **PHOTOGRAPH** is included as a part of my electronic health record. I relieve River Valley Primary Care Services, Inc. of any use of my photograph for treatment, identification, or education purposes acknowledging that uses for any other purposes must be specifically obtained from me.

- I authorize treatment for the identified patient or myself. I also understand that examination and treatment may be by the medical or dental staff defined as Medical Doctor, Doctor of Dentistry, Dental Hygienist, Advanced Practice Nurse, or Physician Assistant. Others services may be rendered by their clinical assistants by direct order of the medical or dental staff. I also understand that examination and treatment may be by a student under the supervision of a clinician or dentist.

- As the parent/guardian for the identified patient, I am consenting for _____ _____, to receive treatment at any RVPCS location. Name of child / minor Date of Birth

_____ _____
Patient/Guardian Signature Date

* ☐ *Please check if patient is incarcerated. Must sign above for consent to treat.*