Pt ID # _________

PATIENT REGISTRATION FORM

3706 N. Roosevelt Blvd Key West, FL

Last Name	First Name	Middle Initial	Preferred Name
Date of birth	**Sex at Birth** ☐ Male ☐ Female ☐ Decline	**Mailing Address** **City** **State** **Zip**	
Home Phone	**Cell Phone**	**What is your marital status?** ☐ Divorced ☐ Married ☐ Single ☐ Domestic partner ☐ Separated ☐ Widowed	
Social Security Number	**Email Address**	**Preferred Pharmacy**	

RESPONSIBLE PARTY INFORMATION

First/Last Name	Employer		Social Security #
Street address	**City**	**State**	**Zip**
Date of birth	**Gender** ☐ Male ☐ Female	**Phone Number**	**Patients Relation to Guarantor**

INSURANCE

Insurance company	Employer	
Policy holder's first and last name	**Policy holder's date of birth**	**Policy holder's social security #**

HEALTH CENTER FUNDING INFORMATION

In order to continue the variety of services that we offer here at RHN and to continue to receive grant funding, we are required to collect the following information on every person that visits our facility. This information is reported as a cumulative number and not reported on individual patients.

What is your household annual income?
- ☐ <$10,000
- ☐ $30,000-49,999
- ☐ $10,000-14,999
- ☐ $50,000-79,999
- ☐ $15,000-19,999
- ☐ $80,000 -99,999
- ☐ $20,000-29,999
- ☐ $100,000+

How many people in your family? (Yourself, spouse and minor children under 18 years) __________

Veteran Status:
- ☐ Veteran
- ☐ Not a veteran

Homeless Status:
- ☐ Shelter ☐ Street
- ☐ Transitional Housing
- ☐ No

Agricultural Status over the last 3 years:
☐ Migrant ☐ Seasonal ☐ No

Student Status:
- ☐ Student full time
- ☐ Student part time

Employment Status:
- ☐ Employed full time
- ☐ Employed part time
- ☐ Unemployed
- ☐ Retired
- ☐ Disabled

Employer Name:
Employer Address:

Racial Group(s):
- ☐ African American/Black
- ☐ Asian
- ☐ Caucasian/White
- ☐ Multiracial
- ☐ Native American/Alaskan Native
- ☐ Pacific Islander
- ☐ Other

Referral Source:
- ☐ Billboard
- ☐ Radio
- ☐ Business/Agency
- ☐ Friend or Family
- ☐ Fair/Festival/Event
- ☐ Hospital/Clinic
- ☐ Newspaper
- ☐ Internet Search

What is your gender identity? **Only if over 12 years of age
- ☐ Male
- ☐ Female
- ☐ Transgender Male/Trans Man/FTM
- ☐ Transgender Female/Trans Woman/MTF
- ☐ Chose not to disclose

Preferred Language:

____

Do you need an Interpreter?
☐ Yes ☐ No

Ethnicity:
- ☐ Hispanic/Latino/Latina
- ☐ Non-Hispanic/Latino/Latina

Do you think of yourself as: **Only if over 12 years of age
- ☐ Lesbian, gay, or homosexual
- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Something else
- ☐ Don't know
- ☐ Choose not to disclose

What pronouns? **Only if over 12 years of age
- ☐ he/him
- ☐ she/her
- ☐ they/them

EMERGENCY CONTACT INFORMATION

Emergency contact	Relationship to patient	Phone number

Pt ID # ________

PATIENT REGISTRATION FORM

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CONSENT TO TREATMENT:

I hereby request and consent to diagnostic procedures, tests, and medical treatment, family planning, birth control methods, and immunizations as deemed advisable by the professional staff of Rural Health Network (RHN). I am aware that a Physician or a Nurse Practitioner may provide the medical care. Services will be in my best interest, or the best interest of my child or legal charge. I understand that this consent to treatment will be in effect as long as I am seen at any of Rural Health Network (RHN). I may cancel this consent in writing.

I consent to be contacted by regular mail, by e-mail or by telephone (including a cell phone number) regarding any matter related to my account by the practice or any entity to which the hospital assigns my account. I also consent to the use of any updated or additional contact information that I may provide by the practice or any entity to which the practice assigns my account, as well as to the use of technology including auto-dialing and/or pre-recorded messages in contacting me.

Signed: **X**____ ____________________

Patient Signature/Parent/Legal Guardian Signature (Please circle one) Date

Please print full name and relationship to patient if the patient cannot sign this document.

____

Full name (print) Relationship

AUTHORIZATION FOR MEDICAL RECORDS RELEASE/REFERRAL AND ASSIGNMENT OF BENEFITS:

I authorize RHN to release medical/social information to persons or agencies directly concerned with and engaged in carrying out a treatment plan for the patient. Also RHN may use and release any part of my medical records necessary to the process of billing third party payers for services rendered on my behalf. I clearly understand that all my information will be kept confidential. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution.

I authorize payment directly to Rural Health Network (RHN) or all medical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non- covered services. Overpayments on any Rural Health Network (RHN) account may be applied to my patient balance. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: **X**____ ____________________

Patient Signature/Parent/Legal Guardian Signature (Please circle one) Date

Please print full name and relationship to patient if the patient cannot sign this document.

____

Full name (print) Relationship

PROTECTED HEALTH INFORMATION DESIGNEE:

I understand that the individuals identified below will be treated by Rural Health Network (RHN) as individuals involved directly in my care or my child's care, and as such RHN will be allowed to release the patient's personal health information to these individuals for the purpose of treatment including making appointments, bringing a minor child for medical treatment, and all other functions normally associated with individual patient care, payment, and health care operations.

Name of Designee: ____________________________________ Relationship to Patient: ________________

Name of Designee: ____________________________________ Relationship of Patient: ________________

I decline to provide a protected health information designee contact for myself or my child at this time.

Patient Signature/Parent/Legal Guardian________________________________Date: ____________________

Pt ID # ________

PATIENT REGISTRATION FORM

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AS A PATIENT, I AGREE TO THE FOLLOWING:

- I agree to treat staff and clients of RHN with dignity and respect.
- I will arrive to my appointment on time.
- I will cancel appointments at least 2 hours before or it will be considered a "No Show". Repeat "No shows" could result in you losing privileges to schedule future appointments per policy.
- I have been given the opportunity to ask any questions I have about my care through RHN.
- I can request a copy of all authorization documents such as Notice of Privacy Practices (HIPAA), Patient responsibilities, and RHN Responsibilities and Duties.
- I understand and am aware children may not be left in the waiting area while I am being treated and I must reschedule my appointment if I do not have appropriate supervision/care for the children.

Signed: **X**____ ________________
Patient Signature/Parent/Legal Guardian Signature (Please circle one) Date

Please print full name and relationship to patient if the patient cannot sign this document.

____
Full name (print) Relationship