PATIENT REGISTRATION FORM

Please PRINT. Please return completed form(s) to Registration.

PATIENT INFORMATION

MRN: _____ **Date:** _____/_____/_____

Name: _____ **Sex/Gender:**_____
FIRST MI LAST PREFERRED NAME

Date of birth: _____/_____/_____ **Social Security No.:** _____-_____-_____

Street Address: _____ **PO BOX:** _____

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

County: _____ **Email:** _____

Home/Mobile Phone: _____ **Work Phone:** _____

Emergency Contact Name: _____ **Relationship:** _____

Emergency Phone #: _____ **Primary Language:** ☐ English ☐ Spanish ☐ Other _____

Religion: _____ **Are Interpreter Services needed?** ☐ YES ☐ NO

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black ☐ Native Hawaiian ☐ White ☐ Pacific Islander ☐ More than one race ☐ Unreported/Refused to Report

Ethnicity ☐ Hispanic ☐ Non-Hispanic
Employed ☐ Full ☐Part time ☐ Unemployed
Student ☐ Full ☐ Part time

Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

Are you a veteran? ☐ YES ☐ NO
Are you a farmworker? ☐ YES ☐ NO
Are you a student? ☐ YES ☐ NO

Are you homeless? ☐ YES ☐ NO
Public Housing? ☐ NO YES ☐ ☐ Stable ☐ Temp ☐ Unstable

Special Needs? ☐ Bariatric ☐ Hearing Impaired ☐ Risk of fall ☐ Short Stature ☐ Speech Impaired ☐ Visually Impaired ☐ Wheelchair ☐ None

Number of persons in Household: Adults: _____ **Children:** _____

RESPONSIBLE PARTY INFORMATION
(Complete this section if Responsible Party is NOT the Patient)

Relationship of Responsible Party: ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other _____

Name: _____ **Sex/Gender:**_____
FIRST MI LAST

Date of birth: _____/_____/_____ **Social Security No.:** _____-_____-_____

Street Address: _____ **PO BOX:** _____

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

Home Phone: _____ **Work Phone** _____

Employer: _____

INSURANCE INFORMATION

Please present your insurance card to the Intake each time you check-in

MRN: _____

PRIMARY INSURANCE

Plan Name: _____ **ID Number:** _____

Address: _____ **Group Number:** _____

Policy Holder: _____ **Effective Date:** _____

Policy Holder's Social Security No.: _____-_____-_____ **Sex:** M ☐ F ☐

Policy Holder's Date of birth: _____/_____/_____

Employer: _____

SECONDARY INSURANCE

Plan Name: _____ **ID Number:** _____

Address: _____ **Group Number:** _____

Policy Holder: _____ **Effective Date:** _____

Policy Holder's Social Security No.: _____-_____-_____ **Sex:** M ☐ F ☐

Policy Holder's Date of birth: _____/_____/ _____

LCHC requires payment on the day of service. This payment includes outstanding deductibles, co-payments, non-covered services, sliding fee payments and any charges remaining after insurance has made payment on your account. Please be advised that your insurance may not cover all of your charges and that you are responsible for any balance on your account and will be billed until that balance is paid. The Sliding Fee Program is for families with low incomes. This program allows patients to get a discount on the charges. You must apply with registration staff with verification of the total income and number of persons in the household. You must reapply for the program every year and payment must be made at time of service. Signing of this form indicates you are aware of above policies and procedures and were advised of the sliding fee program. I hereby authorize assignment of all insurance benefits payable directly to LCHC.

Signed: _____ **Date**: _____/_____/_____

FOR INTERNAL USE ONLY

LCHC Employee Signature: _____

Assigned PCP: _____

Lincoln Community Health Center, Inc.

SLIDING FEE APPLICATION

Name: _____ **DOB:** _____ **MRN:** _____
(Office Use Only)

Sliding Fee Discount Program

The Sliding Fee Discount Program is a federal program that permits Lincoln Community Health Center to discount normal charges for a medical visit. According to law, it requires two pieces of information in order to qualify: the amount of money earned in the household and the number of people who live in the household. In order to be eligible for the Sliding Fee Scale, you must provide accurate and acceptable proof of income as well as list all persons within the household or you will be responsible for 100% of all charges. You must report any changes in family income or number of members in the household when these changes occur. Falsification of this information will result in forfeiture of Sliding Fee Scale privileges and possible release from the practice as it is a violation of Federal Law.

Eligibility

All Lincoln Community Health Center patients are eligible to apply for the slide. Determination of the discount, if any, is dependent upon household income and household size in comparison to the current Federal Poverty Guidelines. The discount may apply to Insurance / Medicare deductibles as well as approved non-covered services. The discount does not apply to insurance co-pays.

Term

Information must be updated every twelve (12) months or with any change of household income or household size.

Definitions and Examples of Acceptable Proof Required

Income Determination

1. Income is based on the gross income of all household members earning income.
   a. Income used to compute poverty status:
   b. Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.
   c. Noncash benefits (such as housing subsidies) do not count.
   d. If a person lives with others, add up the income of all members in the household.
2. Acceptable forms of proof for determining income include the following.
   a. Income Tax Return: A signed copy of the most recent tax return showing Adjusted Gross Income.
   b. Agency letter: A letter from the Social Security Administration, Veterans Administration or Social Service Agency indicating income level.
   c. Unemployment Verification: Paperwork from the Employment Securities Commission (ESC) proving unemployment status and the amount of unemployment compensation being received.
   d. Official documents citing child support or alimony as awarded by a judge.
   e. Official Paperwork: Paperwork documenting retirement, disability, SSI benefits.
   f. Wage Verification Form completed by employer.

Household Size Determination

1. All members of a household who are pooling financial resources including room and board and/or are supporting one another financially are counted as one household.
2. Household size can be documented with any of the following.
   a. A copy of the most recent tax return showing household size.
   b. Social Security card
   c. Birth Certificate
   d. Medicaid cards for any dependent children
   e. Driver's License or State ID cards
   f. Court or government documents that indicate the number of members in household
   g. Rental agreements or a letter from the landlord that indicates the number of household members. Contact information must be provided so that information can be verified.

Identification Determination

1. Form of government-issued picture identification
2. Verification of location of household/residence (i.e. utility bill, mortgage statement or lease)

Complete and sign the attached application

Lincoln Community Health Center, Inc.

SLIDING FEE APPLICATION

Name: _____ **DOB:** _____ **MRN:** _____
(Office Use Only)

Eligibility Determination

TO BE COMPLETED BY PATIENT/GUARDIAN: Please complete ALL your family information below:

Name	Relation	Date of Birth	Income	Frequency	Type of Income Documentation	List all health insurance plans by which you are covered	Annual Deductable
Example: John Doe	Self	5/16/46	$346	weekly	Tax Form	Medicare	None

*****Documentation must be provided by patient or guardian to determine eligibility for Sliding Fee Scale*****

I understand that the information I provide on this form is subject to verification by Lincoln Community Health Center. I certify that the above information is true and correct to the best of my knowledge and that I understand & agree that providing false information can result in me being denied ability to apply for the program; furthermore I agree to adhere to all terms and conditions of the Sliding Fee Discount Program. **I also understand that I must supply proof of income before receiving any additional services, or I will have to pay the full price for those services with no discount.**

_____ _____
Patient/Guardian Signature Printed Name Date

..... (DO NOT write below this line. To be completed by Lincoln Community Health Center employee.) .....

	Acceptable Income Documentation [Enter (x) if verified and obtained]	Calculated Amount Associated with Documentation
	Current Federal Tax Return	
	Wage verification form completed by employer	
	Official Letters/documents from Social Security, Courts, Child Support, ESC, etc.	
Total Income Amount		

Total Number of Family Members Applying for the Sliding Fee Program	

Enter (x) if verified and obtained	Verified and Obtained Information
	Acceptable identification for each family member listed on Sliding Fee Program Application
	All family member(s) name(s) and date(s) of birth listed on Sliding Fee Program Application.

Sliding Fee Category	Sliding Effective Date	Sliding Termination Date

I certify that all information provided has been reviewed and is complete to the best of my knowledge.

_____ _____
Signature of Health Center Employee Printed Name Date

LINCOLN COMMUNITY HEALTH CENTER INC
CONSENT FOR TREATMENT AND NOTICE OF PRIVACY PRACTICE

Patient Name: _____D.O.B:_____ MRN:_____

The following information is to be completed by the patient or the patient's legally authorized representative/parent.

I consent to medical treatment which may include appropriate x-rays, immunizations, and lab work, including HIV testing, for me or for the patient for whom I am the parent or legally authorized representative.

I understand that I am responsible for **ALL CHARGES INCURRED**, regardless of my insurance status. I authorize my insurance provider to pay Lincoln Community Health Center for services rendered. I agree to pay for all co-payments and charges that are not covered by my insurance carrier. I understand that Lincoln Community Health Center may share patient health information with Recovery Innovations International, Durham County Human Services, Local Access to Coordinated Healthcare (LATCH), Project Access of Durham County (PADC), Durham Homeless Care Transition (DHCT) and with other service providers in the N.C. Ryan White CAREWare system; if applicable, according to federal and state law for treatment, payment, and operations.

I certify that the income and other registration information provided by me to Lincoln Community Health Center staff for the purpose of receiving services is accurate. I further understand that my health center records are subject to federal audit, and that if Lincoln Community Health Center determines I have falsified this information, I will be notified and then dropped as a registrant and may no longer receive services at the Center, except in a life threatening emergency.

I consent to receive text messages for appointment reminders. You will be able to opt out at any time.

By signing this statement, I (Print name) _____certify that I have read and
(Legal name)
fully understand the contents of this statement.

Furthermore, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices and The Patient Rights and Responsibilities.

Patient's Signature_____ Date:_____
(If minor, guardian's signature)

Relationship of Legally Authorized Representative to Patient:_____

Witness Signature: _____ Date:_____