Palms Medical Group
Your home for health, wellness, life

Patient Registration Form

Welcome to Palms Medical Group! We are happy you have chosen us for your medical home. To register, please complete this form. Several of the items below help us ensure that we are meeting the needs of the population we serve, so please be as thorough as you can. Let us know if you have any questions or if you need help in completing this form.

1. Patient Information

Date of Birth:	Month:	Day:	Year:	**SSN:**
Legal Name:	**First:**		**MI:**	**Last:**
	Preferred Name:			
Address:	Street Address:			Apartment No.:
	City:		State:	Zip Code:
	Is your housing?: ☐ Stable ☐ Unstable ☐ Temporary			

Are you a Veteran? ☐ Yes ☐ No

Do you live in Public Housing? ☐ Yes ☐ No

Are you Homeless? ☐ Yes ☐ No

If you answered "yes" to being homeless please check one of the following:

☐ Street ☐ Doubling Up

☐ Transitional ☐ Shelter

Migrant Worker? ☐ Yes ☐ No

Seasonal Worker? ☐ Yes ☐ No

(May leave blank for pediatric patients)
Sexual Orientation:

☐ Straight or Heterosexual

☐ Lesbian, Gay, Homosexual

☐ Bisexual

☐ Other: _____

Gender Identity:

☐ Man

☐ Woman

☐ Trans Man

☐ Trans Woman

☐ Genderqueer/Non-binary

Race:

☐ African American/Black

☐ Caucasian/White

☐ American Indian or Alaska Native

Asian (*please specify)*

☐ Asian Indian ☐ Korean

☐ Chinese ☐ Vietnamese

☐ Filipino ☐ Other Asian

☐ Japanese

Native Hawaiian/Pacific Islander

☐ Native Hawaiian

☐ Samoan

☐ Guamanian or Chamorro

☐ Other Pacific Islander

Ethnicity:

☐ Non-Hispanic/ Non-Latino

Hispanic/Latino (Specify)

☐ Mexican/ Mexican American/ Chicano/a

☐ Puerto Rican

☐ Cuban

☐ Another Hispanic Latino/a Spanish Origin

Contact Information:	Would you like to communicate with us via our secure patient portal? If yes, provide your email address so that we can establish a patient portal account for you.		
Home Number:		Work Number:	Cell Number:
Language:	☐ English ☐ Spanish ☐ Other:_____ ☐ I request language translation services Hearing disabled or need sign language interpreter services? ☐ Yes ☐ No		
Do you have an advanced healthcare directive? ☐ **Yes** ☐ **No** *If yes, please bring PMG a copy to be included in your health record*		If NO, would you like more information? ☐ Yes ☐ No	

2. Emergency Contact

Please provide contact information for the person you want us to contact in the event of an emergency. We will identify ourselves as Palms Medical Group.

First Name:	**Last Name:**		**Relationship:**	
Street Address:	Apt. No.:	City:	State:	Zip:
Cell Number:	Home Number:	Work Number:	Email:	

3. Communication to Family and Others Involved in Your Care

Please list any family members or others who may be involved in coordinating your care. Also, please indicate what kind of information may be shared with each individual. **If patient is a minor, please list both parents/guardian.**

		Type of Information			
Name	**Relationship to Patient**	**All**	**Appointment**	**Medical/Dental/Behavioral Health**	**Bill/Payment**

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Patient Registration Form *(continued)*

Patient Name: _____
DOB: _____

Are You Insured? ☐ Yes ☐ No You may be eligible for a discount for your services. In order to determine your eligibility, you must provide total household income. Until we receive your documentation, you will be responsible for the full fee for your services.		
Insurance We Do NOT Accept:	**If we do not take your insurance OR you have an HMO**, we encourage you to select a provider who takes your insurance. Choosing to get your care with us will mean being charged for the full fee of your care and seeking reimbursement from your insurer.	
Sex/Gender Marker with Insurance Company:	PMG recognizes your gender identity. For insurance billing purposes, what sex/gender marker is on file with your insurance company? ☐ **Male** ☐ **Female** Is your legal name on your insurance card? ☐ **Yes** ☐ **No It's listed as:** _____	
Insurance Information:	Insurance Company:	Identification Number:
	Group Number:	Insurance Contact Number: *(on back of card)*
	In whose name is your insurance? ☐ Self ☐ Other: _____	If private/commercial insurance: ☐ Employer Paid ☐ Individual Paid ☐ Other: _____
Secondary Insurance Information:	Insurance Company:	Identification Number:
	Insurance Contact Number *(on back of card)*:	
To comply with Federal law, we are required to collect information about family income and family size from all patients to determine the percentage of patients by Federal Poverty Level.	Annual Family Income: $_____	Family Size: _____ *(includes spouse, dependent children, or other people dependent on you)*

Acknowledgement of Responsibility for Payment for Services and Assignment of Benefits

- I understand that I am responsible for all charges and fees for my care, except any that might be covered by insurance accepted by PMG.
- I understand that payment, including co-insurance, co-pays and self-pay/sliding fee payments, is due at the time of service.
- For uninsured or underinsured clients: I understand that if my income changes, I will bring in documentation of those changes to the Finance department. They will re-assess my eligibility for insurance on the sliding fee scale and/or grant-supported care.

Dental Patients:

- I understand that some services may not be considered eligible to be covered by my dental benefits through my dental insurance provider. I understand that my dental insurance coverage has certain restrictions and limitations, such as authorization requirements, waiting periods, as well as non-covered services. I understand that I am financially responsible for any and all related charges if they are not covered by my dental insurance.

Consents and Acknowledgements

In order for you to become a patient, we need your consent to provide you with care. We also need you to acknowledge that we have provided you with certain important information and documents. If you have any questions about any of this information or need help completing this form, please do not hesitate to ask a member of our staff. It is important to us that you feel comfortable with all of this information. By signing, you are indicating that you understand the information, have been given a chance to ask questions, and are giving your consent.

GENERAL CONSENT TO TREAT

I voluntarily agree to receive services from PMG, and authorize the providers of PMG to provide such care, treatment, or services as are considered necessary and advisable for me. I understand that I should participate in the planning for my care and that I have a right to refuse interventions, treatment, care, services or medications at any time to the extent the law allows. I know that the care I will receive may include tests, injections, and other medications, etc., that are based on established medical criteria, but not free of risk. Finally, I know that PMG sometimes has students/residents being trained as doctors, nurses, therapists and other health care providers who might be helping to care for me. These individuals are under the supervision of licensed providers. I understand that PMG is committed to involving me in my care and that no one can be given care at PMG without agreeing to the care unless there is an emergency. If there is an emergency, I know that someone at PMG may help me without waiting for me to say okay. I understand that some services require me to sign another Informed Consent to Treatment so I may be asked to complete that later.

NOTICE OF PRIVACY PRACTICE

I have been given a copy of PMG's Notice of Privacy Practices and I understand that PMG is required by law to protect my personal health information. I have had the chance to ask questions about PMG's Notice of Privacy Practices and feel comfortable with the protections that it offers me. I understand that there are times when the law allows my personal health information to be shared with individuals or entities outside of PMG, including but not limited to for treatment, payment and operations purposes, when required by law, and in connection with the mandatory reporting of certain diseases.

HEALTH INFORMATION EXCHANGE

I understand that PMG participates in certain health information exchanges with hospitals and health centers located in the area. I have been informed that my health information, including limited information relating to mental health that I may receive at PMG, will be shared with these exchanges. Notes from my behavioral health provider will not be shared, but diagnosis codes and a history of my visits will be shared. My understanding is that information about me is being shared with providers and public health officials outside of the health center for treatment purposes, in order to better coordinate my care and to assist providers and public health officials in making more informed decisions.

PATIENT RIGHTS AND RESPONSIBILITIES

I have been given a copy of the PMG Patient Rights and Responsibilities document and understand that both the Rights and the Responsibilities laid out in that document must govern my interactions at PMG. I also understand that PMG and I are responsible for adhering to the Rights and Responsibilities. I understand that I have a right to file a complaint or grievance with PMG.

RELEASE OF INFORMATION FOR BILLING AND CONSENT TO REIMBURSE

I know that PMG needs to send parts of my personal health information to organizations that help pay for my care, such as my insurance company. I allow PMG to release the relevant parts of my records so that my care can be paid for. If I do not feel comfortable with this, then I understand that I can request a higher level of privacy protection than is afforded to me under the Health Insurance Portability and Accountability Act (HIPAA).

CONSENT TO COMMUNICATIONS VIA E-MAIL

I understand that PMG may need to communicate with me via e-mail regarding some aspects of my care, including appointments, billing, prescriptions, and test results. I understand that unencrypted e-mail communication is not a confidential method of communication, and that there is a risk that e-mail communications may be intercepted by third parties or transmitted to unintended parties. By signing below, I am consenting to such e-mail communications with the understanding that PMG will, to the best of its ability, limit the information about me that it includes in e-mail communications to me.

ACKNOWLEDGMENT OF DUTY TO REIMBURSE PMG FOR HEALTH CARE SERVICES

I understand that PMG offers a Sliding Fee Scale of discounted health care items and services to individuals who are deemed unable to pay based on their level of income. In order to be eligible for PMG's Sliding Fee Scale of discounted services I will need to provide PMG's financial team with documents establishing that I meet income eligibility requirements. If I do not provide the required documents to PMG, I am responsible for paying my fees for medical, behavioral health, or dental services received at PMG in full at the time of service. I also understand that if I am an insured patient with insurance PMG does not accept, or an insured patient with a copay obligation who fails to pay fees or copays due at the time of service, I will not be scheduled for future appointments until such time as my outstanding fees or copays are paid.

Patient Acknowledgement of Financial Obligation

PREAMBLE

Palms Medical Group ("PMG") is a Federally Qualified Health Center ("FQHC" or "Health Center") that is subject to Section 330 of the Public Health Service Act. Section 330 specifies that Health Centers must assure that no patient will be denied services due to their inability to pay for such services. It also requires Health Centers to adopt written policies and procedures to maximize collections and reimbursement for their costs in providing health services.

I UNDERSTAND THAT I AM RESPONSIBLE FOR:

- Contributing to the cost of my care and treatment as my health insurance coverage requires and based on my ability to pay;
- Providing PMG with the information it needs to receive reimbursement for the treatment or services it provides to me;
- Requesting consideration for discounted fees under PMG's Sliding Fee Scale based on my level of income, and providing documentation to support eligibility for discounted fees that may be requested by PMG's financial services department;
- Assisting the Insurance Navigators with any application for insurance or public benefits that I may be entitled to;
- Paying my co-payment (if applicable) when I check-in for my appointment and paying my deductible or any other fees that may be owed at the conclusion of the office visit;
- Paying my fees for medical, behavioral health, or dental services received at PMG in full at the time of service, as requested by PMG if I have been deemed a self-pay patient based on the fact that I have insurance coverage that PMG does not accept but have elected to remain in care at PMG.