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. 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 you need help in completing this form.

## 1. PATIENT INFORMATION

| | | | |
|---|---|---|---|
| **LEGAL NAME:** | **Last:** | **First:** | **Middle:** |
| **SSN:** | | **Date of Birth:** | |
| **MAILING ADDRESS:** | Street Address: | | Apartment No.: |
| | City: | State: | Zip Code: |
| **EMAIL:** | | | |
| **HOME #:** | | **CELL #:** | **OK to leave detailed voice/text message?** ☐Yes ☐No |

**PREFERRED COMMUNITATION TYPE** *(CHECK ALL THAT APPLY)*: ☐ Phone ☐Email ☐Text ☐ I **OPT OUT** of receiving messages via email or text

## 2. EMERGENCY CONTACT: Please provide contact information for the person you want us to contact in the event of an emergency.

| | | |
|---|---|---|
| **LAST NAME:** | **FIRST NAME:** | **RELATIONSHIP:** |
| **CELL NUMBER:** | **HOME NUMBER:** | |

## 3. OTHER DEMOGRAPHIC INFORMATION

**MARITAL STATUS:**
☐Single
☐Married
☐Divorced
☐Separated
☐Widowed

**STUDENT STATUS:**
☐FT Student
☐PT Student
☐Not a Student

**ETHNICITY:**
☐Non-Hispanic/Non-Latino
☐Hispanic/Latino
☐Mexican
☐Chicano
☐Puerto Rican
☐ Other Spanish culture
☐Cuban

**RACE:**
☐African American/Black
☐Alaska Native
☐White
☐Greek
☐Asian
☐Native American Indian
☐Native Hawaiian
☐Chamorro/Guamanian
☐Multiracial
☐Asian Indian
☐Chinese
☐Filipino
☐Japanese
☐Korean
☐Vietnamese
☐Samoan
☐Other Pacific Islander
☐Other: _____

Primary Care Provider: _____

Primary Dental Provider: _____

Primary Language, if Not English: _____

Do you need Interpreter Services? ☐ Yes ☐ No

## 3. HEALTH CENTER FUNDING INFORMATION

**As a Health Center that receives Federal funding, we are required to collect this information. All answers are required and confidential.**

**Are you a US Veteran?**
☐Yes ☐No

**Agricultural Worker Status:**
☐Migrant ☐Seasonal

**Do you live in Public Housing?**
☐Yes ☐No

**Are you Homeless?**
☐Yes ☐No

**SEX:**
☐Male
☐Female

**SEXUAL ORIENTATION** *(Under 18 optional):*
☐Straight or Heterosexual
☐ Lesbian, Gay, Homosexual
☐Bisexual
☐Something else
☐ Don't know
☐Prefer not to disclose

**FAMILY FINANCIAL INFORMATION**
Number of family members living in your household: _____
Annual Household Income:
$ _____

**ADVANCE DIRECTIVE**
Do you have an Advance Directive?
☐ Yes ☐ No
If No, would you like an Advance Directive packet?
☐ Yes ☐No

## 4. GUARANTOR (person responsible for paying the bill)

☐ Patient☐ Custodial Parent ☐ Guardian (proof required)

**NAME:**

**ADDRESS:**

**PHONE:**

**SSN:**

**DOB:**

## 5. PRIVACY

Please list the names of those involved in your care and what type of information may be shared with them. If patient is a minor, please list both parents.

| NAME/RELATIONSHIP | All Info | Bill Info | Appt | Med/ Dental |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |

## 4. PEDIATRIC PATIENTS TRUSTED INDIVIDUALS: For parent or legal guardian of patients ages 17 and younger

**I give consent for the following individuals to bring my child to appointments. It is your responsibility to notify the practice if this list changes. If your child is of driving age and you consent to them coming to appointments alone, please list the child's name here.**

| NAME/RELATIONSHIP | |
|---|---|
| **1.** | **3.** |
| **2.** | **4.** |

**Parent/Legal Guardian signature:**

# Palms Medical Group
# PATIENT CONSENTS AND ACKNOWLEDGMENTS

***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.***

**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 nearest PMG Office. They will re-assess my eligibility for insurance on the sliding fee scale and/or grant-supported care.
- 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.
- 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;

**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.

**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, dentists, 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. I understand that if I am the parent/guardian of a minor patient that I have the right to consent to treatment. Accordingly, I hereby consent to the treatment of the minor patient listed on this form including consenting to the prescribing of medicinal drugs if medically indicated.

**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, 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. I understand that PMG my need to communicate with me via e-mail regarding security incidents such as a data breach and I agree to such communication. 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.**

| Signature | Date | Witness | Date |
|---|---|---|---|
| | | | |