Promise Community Health Center
Patient Registration

PATIENT INFORMATION

Last Name	First Name	MI	DOB	SS#

Street Address	City	State	Zip	County

CONTACT INFORMATION

Primary Phone Number	☐ Home ☐ Cell ☐ Work	Secondary Phone Number	☐ Home ☐ Cell ☐ Work
Promise may contact me for clinical/appointment reminders by using the following methods (check all that apply): ☐ Email ☐ Phone ☐ Text message (Standard data/messaging rates may apply)		**Email:**	

Cell phone carrier: ☐ Verizon ☐ iWireless/T-Mobile ☐ US Cellular ☐ AT&T Other:_______________

PATIENT DEMOGRAPHICS

Primary Language Spoken	Race (Check all that apply)	Ethnicity
☐ English ☐ Spanish ☐ Other:__________ **Would you like an interpreter?** ☐ Yes ☐ No	☐ Asian ☐ Black ☐ White ☐ Central American Indian ☐ American Indian/Native Alaskan ☐ Pacific Islander ☐ Native Hawaiian ☐ Other: ____________________	☐ Hispanic/ Latino ☐ Non-Hispanic/ Latino

Gender Identity: Do you think of yourself as:	Sexual Orientation: Do you think of yourself as:	Marital Status	Student	Employment Status
☐ Male ☐ Female ☐ Female-to-Male/Transgender Male/Trans Man ☐ Male-to-Female/Transgender Female/Trans Woman ☐ Genderqueer, neither exclusively male nor female ☐ Other, please specify:	☐ Straight or heterosexual ☐ Lesbian, gay, or homosexual ☐ Bisexual ☐ Something else ☐ Don't know	☐ Single ☐ Married ☐ Divorced ☐ Widowed	☐ Full-Time ☐ Part-Time ☐ Not a student	☐ Full-Time ☐ Part Time ☐ Not Employed ☐ Retired

Employer	Zip Code	Occupation	Military Veteran?	Migratory or Seasonal Agricultural Worker?
			☐ Yes ☐ No	☐ Yes ☐ No

GUARANTOR (Person To Be Billed, Check here if same as patient ☐)

Last Name	First Name	MI	DOB	SS#

Street Address	City	State	Zip	Home Phone	Cell Phone

MEDICAL INSURANCE

	Insurance Company	Policy Holder Name	Relationship to patient	DOB	M/F	Employer	Zip Code
1.							
2.							

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

Assignment of Insurance Benefits, Release of Information and Authorization of Treatment.
I the undersigned authorize my insurance benefits to be paid directly to the provider of **Promise Community Health Center** for services render. I understand that I am ultimately financially responsible for any balance due for approved and covered charges not paid by insurance. I hereby authorize Promise CHC to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all my insurance claim submissions. I understand that payment is expected at the time services are rendered. A copy of this is as valid as the original.

Patient/Guardian Signature: ______________________________ **Date:** ______________________________

Relationship to Patient:______________________________

Promise Community Health Center

HIPAA Authorization Form

Promise Community Health Center (PCHC) has taken measures to protect all of our patients' private medical information. PCHC will not release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices.

Your protected health information will be used by PCHC or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. Please review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice and request a copy of the Notice of Privacy Practices for your own records. See the receptionist to receive a copy.

You may request a restriction on the use or disclosure of your protected health information. PCHC may or may not agree to restrict the use or disclosure of your protected health information. If PCHC agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the Federal Privacy Standards.

You may revoke this consent to the use and disclosure of your protected health information. You must revoke consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Please see the receptionist with any questions prior to signing this authorization form.

PERSONS AUTHORIZED TO OBTAIN MEDICAL INFORMATION

Patient Name: ___________________________ If patient under 18 or has guardian, name of guardian: ___________________________

I [patient/guardian] give permission to Promise Community Health Center to disclose health and/or billing information to the individuals identified below that are involved in patient care or payment of care. I understand PCHC is not responsible for the information provided as long as it is given to a person that I have listed below.

Date of Birth must be provided so that our office can verify that we are speaking to the correct person.

Name	Relationship	Phone	DOB
Name	Relationship	Phone	DOB

PATIENT CONSENT AND ACKNOWLEDGEMENT

I have reviewed this consent form & give my permission to PCHC to Use & Disclose my health information in accordance of the Federal Privacy Standards.

I understand that, under HIPAA laws, I have certain rights to privacy regarding my protected information. I understand that this information can and will be used for: **Treatment, Payment, and Healthcare Operations.** I have received, read and understood your Notice of Privacy Practices containing more complete description of the uses and disclosures of my health information. I understand that Promise Community Health Center has the right to change its Notice of Privacy Practice from time to time and that I may contact them at any time to receive a current copy.

Patient/Guardian Signature: ____ Date: ____________________

Relationship to patient: ____________________________________