Delta Health Center, Inc.

PATIENT REGISTRATION (PLEASE PRINT)

Patient Name: Last_____ First_____ MI____ Preferred Name_____ Date of Birth_____ MM/DD/YYYY

Previous Name: Last_____ First_____ MI___ Social Security #_____

Address:_____ City _____ State_____ Zip Code_____

Permanent Address:_____ City_____ State_____ Zip Code_____ If different from above

Home Phone: (____)_____-_____ Cell Phone:(____)_____-_____ Email Address_____

If you are 18 years or older, do you have an advanced directive? __Yes __No If No, would you like further information? __ Yes __No

If you are under 19, the Department of Public Health requires that you provide your parent/guardian name and contact information:

Parent/Guardian Name_____ Parent/Guardian Contact Info:_____

Emergency Contact:_____ Relationship:_____ Emergency Contact #:_____

Delta Health Center, Inc. is required to report various types of data in an aggregated (non-identifying) manner regarding the population DHC serves. Please check the appropriate categories below: (DHC protects your privacy. Please read and keep for your records the DHC Notice of Privacy Practices and the DHC Patient Bill of Rights.)

What is your Marital Status?
___Married
___Single
___Divorced
___Widowed
___Separated

Student?
__Yes __No
If Yes, Name of School

What is your Racial background? (check all that apply)
___Asian
___Native Hawaiian
___Other Pacific Islander
___Black/African American
___American Indian/Alaskan Native
___White
___Other
___Choose not to respond

Are you a veteran of the U.S. Military? ___Yes ____No

Are you of Hispanic or Latino Descent? ___Yes ____No

Do you need an Interpreter?
___Yes ____No
What Language?

What sex were you assigned at birth?
___Male ___Female
___Choose not to disclose

Do you think of yourself as:
___Lesbian or Gay
___Straight (not lesbian or gay)
___Bisexual
___Something Else_____
___Don't Know
___Choose not to disclose

What is your current gender identity?
___Male
___Female
___Transgender Male/Female to Male
___Transgender Female/Male to Female
___Other_____
___Choose not to disclose

How would you characterize your current living arrangements?
___Homeowner ___Homeless/Shelter ___Transition Housing ___Other_____
___Rent ___Doubling Up ___Homeless/Street ___Do Not Know

Are you an agricultural migrant worker, dependent of a migrant worker or a retired migrant worker? ___Yes ___No

Are you a seasonal agricultural worker, family member of a seasonal worker, or a retired seasonal worker? ___Yes ___No

Do you live in or near public housing? ___Yes ___No

Please circle your household size in the table below, then go across the row and circle your household income range.

Household Size	Household Income			
1	below $12,760	$12,761 - $19,140	$19,141 - $25,520	above $25,521
2	below $17,240	$17,241 - $25,860	$25.861 - $34,480	above $34,481
3	below $21,720	$21,721 - $32,580	$32,581 - $43,440	above $43,441
4	below $26,200	$26,201 - $39,300	$39,301 - $52,400	above $52,401
5	below $30,680	$30,681 - $46,020	$46,021 - $61,360	above $61,361
6	below $35,160	$35,161 - $52,740	$52,741 - $70,320	above $70,321
7	below $39,640	$39,641 - $59,460	$59,461 - $79,280	above $79,281
8	below $44,120	$44,121 - $66,180	$66,181 - $88,240	above $88,241
9	below $48,600	$48,601 - $72,900	$72,901 - $97,200	above $97,201
10	below $53,080	$53,081 - $79,620	$79,621 - $106,160	above $106,161

Name of Primary Insurance:_____ MO__ PPO__ POS__ Group #_____

Responsible Party/Subscriber:_____ Relationship:_____ Policy #:_____

Subscriber *(if not self)* Birthdate:_____ Social Security #_____ Contact #_____

Address *(if different from above & not self)*:_____ City_____ State____ Zip Code_____

Name of Secondary Insurance:_____ MO__ PPO__ POS__ Group #_____

Responsible Party/Subscriber:_____ Relationship:_____ Policy #:_____

Subscriber *(if not self)* Birthdate:_____ Social Security #_____ Contact #_____

Address *(if different from above & not self)*:_____ City_____ State____ Zip Code_____

DHC is eligible to provide financial assistance on DHC healthcare to individuals that qualify. It is possible you may be eligible even if you have insurance. Do you wish to participate in this sliding fee discount program?

___Yes (Please complete page 3.) ____No (Complete your registration by reading and signing page 2.) ___Do Not Know

Patient/Guardian Signature_____ Date_____

Printed Patient Name _____ Birthdate _____

Delta Health Center Patient Information and Policies

NO SHOW & APPOINTMENT SCHEDULING POLICY

Your medical provider wants to make sure that you and other area residents have access to high-quality medical care when needed. To ensure maximum access to medical services for all of our patients, please be aware of the following appointment policies:

***Scheduled Appointments*:** Although we will make every effort to remind you of your upcoming medical appointment by phone, mail, or email, you are ultimately responsible for remembering your appointment date and time.

Cancelling Appointments: If you cannot make your scheduled appointment, you must call us at least three (3) days in advance to let us know, so that we can offer your appointment to another patient. Failure to provide a 24-hour notice counts as a missed appointment.

***Missed Appointments*:** Because of the critical lack of access to medical services in our area, missed appointments are taken very seriously. If you miss one appointment, you will be documented as having missed an appointment. If you miss a second appointment without proper notice within the same calendar year, you will be placed on a **"NO SHOW STATUS,"** and subsequent visits will only be on a "walk-in basis."

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO DELTA HEALTH CENTER, INC. & CONSENT FOR TREATMENT

I hereby authorize Delta Health Center, Inc. (DHC) and its employees and agents to release my medical records documenting my examination and treatment, including AIDS-related testing and/or substance abuse information upon valid request.

I hereby assign payment directly to DHC for any medical/surgical procedures performed. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. I agree to be financially responsible to DHC for all charges in the event that I have no insurance or my insurance is rejected and for any balance or fee not covered by my insurance and/or determined to be my responsibility. I understand and acknowledge that if DHC files my insurance claim, I will remain responsible for the account, and I will be expected to pay any amount due if my insurance does not pay the claim within 45 days. I acknowledge that any amounts quoted as my "out-of-pocket costs" are only an estimate, and that the exact determination of my financial responsibility will be made after my insurance company processes the claim. Payment is expected at the time of service. Methods of payment accepted include check, cash, debit and credit card.

I further agree to pay all costs of collection, including reasonable attorney's fees, at the legal rate of interest on the account until paid in full, and I agree to waive all rights of exemption under the Constitution and the laws of the State of Mississippi.

I hereby request and authorize all doctors, nurses, technicians or affiliated medical personnel, hospitals and health care facilities to furnish all records and reports, including x-rays, photostatic copies, and abstracts or excerpts of all records, and any other information requested relating to any hospitalizations, examinations, treatments, tests or opinions concerning any condition for which I am presently being treated, including AIDS-related testing, psychiatric or substance abuse information. A copy of this authorization shall be as valid as the original of this document.

GENERAL CONSENT TO TREATMENT

By signing below, I (or my authorized representative on my behalf) authorize DHC physicians, practitioners, dentists, and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test, or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

RIGHT TO REFUSE TREATMENT

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating healthcare providers. I also understand that the practice of medicine is not an exact science, and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

I acknowledge that I have read the above copy of Delta Health Center's No Show & Appointment Scheduling Policy, the Authorization to Release Information to Pay Benefits to Delta Health Center, Inc., the Consent for Treatment, and the Right to Refuse Treatment Policies. I have also received a copy for my personal records of the Delta Health Center's Notice of Privacy Practices and the Patient Bill of Rights citing federal policies for privacy further explaining my rights as a patient.

Patient/Guardian
Signature: _____ Date_____ Witness Signature: _____ Date_____

Patient/Guardian Printed Name_____ Witness Printed Name: _____

FOR OFFICE USE ONLY Date Acknowledgement and Information Received _____Intake Consultant_____
Reason not obtained: _____

Notes on Sliding Fee – Verification	