



# 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.)**

<b>What is your Marital Status?</b> <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	<b>What is your Racial background? (check all that apply)</b> <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Choose not to respond	<b>Are you a veteran of the U.S. Military?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Do you think of yourself as:</b> <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Straight (not lesbian or gay) <input type="checkbox"/> Bisexual <input type="checkbox"/> Something Else _____ <input type="checkbox"/> Don't Know <input type="checkbox"/> Choose not to disclose
		<b>Are you of Hispanic or Latino Descent?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Student?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If Yes, Name of School</small>		<b>Do you need an Interpreter?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No What Language? _____	
		<b>What sex were you assigned at birth?</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Choose not to disclose	
<b>How would you characterize your current living arrangements?</b> <input type="checkbox"/> Homeowner <input type="checkbox"/> Homeless/Shelter <input type="checkbox"/> Transition Housing <input type="checkbox"/> Other _____ <input type="checkbox"/> Rent <input type="checkbox"/> Doubling Up <input type="checkbox"/> Homeless/Street <input type="checkbox"/> Do Not Know		<b>What is your current gender identity?</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male/Female to Male <input type="checkbox"/> Transgender Female/Male to Female <input type="checkbox"/> Other _____ <input type="checkbox"/> Choose not to disclose	

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 (Add \$4,720 for additional household members above 10)				
1	below \$15,060	\$15,061- \$20,783	\$20,784- \$26,355	\$26,356- \$30,120	above \$30,121
2	below \$20,440	\$20,441- \$28,207	\$28,208- \$35,770	\$35,771- \$40,880	above \$40,881
3	below \$25,820	\$25,821- \$35,632	\$35,633- \$45,185	\$45,186- \$51,640	above \$51,641
4	below \$31,200	\$31,201 - \$43,056	\$43,057- \$54,600	\$54,601- \$62,400	above \$62,401
5	below \$36,580	\$36,581- \$50,480	\$50,481- \$64,015	\$64,016- \$73,160	above \$73,161
6	below \$41,960	\$41,961- \$57,905	\$57,906- \$73,430	\$73,431- \$83,920	above \$83,921
7	below \$47,340	\$47,341- \$65,329	\$65,330- \$82,845	\$82,846- \$94,680	above \$94,681
8	below \$52,720	\$52,721- \$72,754	\$72,755- \$92,260	\$92,261- \$105,440	above \$105,441
9	below \$58,100	\$58,101- \$80,178	\$80,179- \$101,675	\$101,676- \$116,200	above \$116,201
10	below \$63,480	\$63,481- \$87,602	\$87,603- \$111,090	\$111,091- \$126,960	above \$126,961

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 \_\_\_\_\_



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



Printed Patient Name

Birthdate

### Application for the Sliding Fee Discount

It is the policy of Delta Health Center, Inc., to provide essential services regardless of the patient's ability to pay. A Sliding Fee Discount is available based on household size and income. Please complete the following information to determine if you or members of your family are eligible for the sliding fee discount program.

Patient Name \_\_\_\_\_ Patient ID # \_\_\_\_\_

Last First M.I.

How many people, including yourself, are living in your household: \_\_\_\_\_

Name of Household Members	Relationship	Birthdate	Income	Please check method of income calculation
1) Yourself	Self			<input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily <input type="checkbox"/> Other _____
2)				<input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily <input type="checkbox"/> Other _____
3)				<input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily <input type="checkbox"/> Other _____
4)				<input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily <input type="checkbox"/> Other _____
5)				<input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily <input type="checkbox"/> Other _____
6)				<input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily <input type="checkbox"/> Other _____
7)				<input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily <input type="checkbox"/> Other _____
8)				<input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily <input type="checkbox"/> Other _____
9)				<input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily <input type="checkbox"/> Other _____
10)				<input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily <input type="checkbox"/> Other _____
Total Household Income				
Slide level for payment based on household income: _____ % of charge				

I hereby certify that the information shown above is correct, and I further understand that verification of income is required for approval. Also, I understand that I must provide this information at least yearly to receive sliding fee discounts for service. Any false statements, documents or concealment of a material fact will disqualify me from receiving sliding fee discounts.

\_\_\_\_\_  
Patient/Guardian/Responsible Party Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**FOR OFFICE USE ONLY**

Documentation of attempt made for third-party verification or type(s) of verification received:

Staff Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_



***This page is for Patient's Personal Records and intended to be kept by the patient.***

***Frequently Asked Questions on Third Party Verification Documents***

**What do I include in calculating my income? Income includes but is not limited to:**

- The full amount of gross income earned before taxes and deductions.
- The net income earned from the operation of a business, i.e., total revenue minus business operating expenses. This also includes any withdrawals of cash from the business or profession for your personal use.
- Monthly interest and dividend income credited to an applicant's bank account and available for use.
- The monthly payment amount received from Social Security, annuities, retirement funds, pensions, disability and other similar types of periodic payments.
- Any monthly payments in lieu of earnings, such as unemployment, disability compensation, SSI, SSDI, and worker's compensation.
- Monthly income from government agencies excluding amounts designated for shelter, and utilities, WIC, food stamps, and childcare.
- Alimony, child support and foster care payments received from organizations or from persons not residing in the dwelling.
- All basic pay, special day and allowances of a member of the Armed Forces excluding special pay for exposure to hostile fire.

**What items should I have with me or provide to DHC as third party proof of income? The following items are accepted as third party proof of income:**

- Current pay stubs
- Tax Forms: W-2 or 1099
- Most recent profit and loss statements, if self-employed
- Letter from your employer
- Documents showing income from unemployment, social security disability or death benefits, alimony, child support, public assistance pension, adoption assistance, divorce decree, separation agreement, or other court filed agreement with amount and length of agreement.

**Self-declaration should only be used if third party verification of income is unavailable on a patient's first DHC visit.** DHC staff are expected to have exhausted all alternative options for verifying income prior to use of a self-declaration of income.



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### NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Delta Health Center, Inc. uses health information about you for treatment, to obtain payment for treatment for administrative purposes and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of Delta Health Center, Inc.

#### **How Delta Health Center, Inc. May Use or Disclose Your Information**

**For Treatment:** Delta Health Center, Inc. may use your health information to provide you with medical treatment or services. For example; information obtained by a health care provider such as a physician, dentist, nurse, or other person providing health services to you will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.

**For Payment:** Delta Health Center, Inc. may use and disclose your health information to others for purposes of receiving payment for treatment and services that you received. For example; a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis and treatment or supplies used in the course of treatment.

**For Health Care Operations:** Delta Health Center, Inc. may use and disclose health information about you for operational purposes. For example; your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- Evaluate the performance of our staff,
- Assess the quality of care and outcomes in your case and similar cases,
- Learn how to improve our facilities and services, and
- Determine how to continually improve the quality and effectiveness of the health care we provide.

**Appointments:** Delta Health Center, Inc. may use your information to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

**Fund Raising:** Delta Health Center, Inc. may use your health information to contact you to raise funds for Delta Health Center, Inc.

**Required by Law:** Delta Health Center, Inc. may use and disclose information about you as required by law. For example; Delta Health Center, Inc. may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence, and
- To assist law enforcement officials in their law enforcement duties.

**Public Health:** Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

**Decedents:** Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

**Food and Drug Administration (FDA):** Your information may be disclosed to the FDA, or persons under the jurisdiction of the FDA, information relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

**Organ/Tissue Donation:** Your health information may be used or disclosed for organ, eye, or tissue donation purposes.

**Research:** Delta Health Center, Inc. may use your health information for research purposes when an institution review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

**Health and Safety:** Your health information may be disclosed to avert a serious threat to the health and safety of you or any other person pursuant to applicable law.

**Health-Related Communications:** Your information may be used to provide special customer care service. Under this program, we may contact you, consistent with applicable law, to provide reminders or information about alternative treatments (including the availability of clinical trials) or other related health-related benefits and services that may be of interest to you.

**Government Functions:** Your information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.

**Workers' Compensation:** Your health information may be used or disclosed in order to comply with laws and regulations to Workers' Compensation.

**Other uses:** Other uses and disclosures will be only with your written authorization and you may revoke the authorization except to the extent Delta Health Center, Inc. has taken action in reliance on the authorization.



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## Delta Health Center, Inc. PATIENT BILL OF RIGHTS

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation or use in a civil, criminal or administrative action or proceeding, and protected health information is subject to law that prohibits access to protected health information as provided by 45C.F.R. 164.524.

You have the right to request a restriction of your protected health information. This means you may ask us to use or disclose any part of your protected health information for the purposes of treatment, payment or health operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this **Notice of Privacy Practices** as provided by 45C.F.R. 164.522. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you **may** request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, electronically.

You have the right to have your physician, amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice. Delta Health Center, Inc. will inform you of any changes. You then have the objective to withdraw as provided in this notice by 45 C.F.R. 164-528. This notice was revised and became effective March 24, 2016.