PRIMARY HEALTH SOLUTIONS
PATIENT REGISTRATION/FINANCIAL FORM

Today's Date: Month / Day / Year

PATIENT INFORMATION:

Last Name	First Name	MI	Nickname	Social Security #	Birth Date Month / Day / Year

☑ Birth Gender:
☐ Female
☐ Male

☑ Current Gender:
☐ Male
☐ Female
☐ Undifferentiated

☑ Gender Identity:
☐ Choose not to Disclose
☐ Female
☐ Female-to-Male (FTM) Transgender Male
☐ Genderqueer, neither exclusively Male or Female
☐ Male
☐ Male-to-Female, (MTF) Transgender Female
☐ Other, please specify _____

☑ Sexual Orientation:
☐ Bisexual
☐ Choose not to disclose
☐ Don't Know
☐ Lesbian, Gay, Homosexual
☐ Other: _____
☐ Straight or heterosexual

☑ Preferred Pronoun:
☐ Asked but unknown
☐ Declined to Answer
☐ He, Him, His
☐ Other
☐ She, Her, Hers
☐ They, Them, Theirs
☐ Ze, Hir

Patient Billing Address (Responsible Party)	City	State	Zip
Patient Residence (if different)	City	State	Zip

☑ Preferred Language:
☐ English ☐ Spanish
☐ French ☐ German
☐ Nepali ☐ Russian
☐ Other: _____

☑ Religion:
☐ Christian ☐ Agnostic ☐ Atheist
☐ Buddhist ☐ Hindu ☐ Unknown
☐ Islamic ☐ Scientology
☐ Other: _____

☑ Marital Status:
☐ Single ☐ Married ☐ Widowed
☐ Divorced ☐ Life Partner
☐ Other: _____

☑ Student Status:
☐ Full Time Student
☐ Not a Student
☐ Part-Time Student

☑ All that apply:
☐ Veteran
☐ Smoker
☐ None of the Above

Can we send notifications?
☑ All that Apply:
☐ Opt Out
☐ Email ☐ Phone ☐ Text ☐ Voicemail

☑ Which Contact # You Prefer:
☐ Home Phone #
( )
☐ Day/Work Phone #
( )
☐ Cell #
( )

Emergency Contact Name	Emergency Contact Relationship	Emergency Contact Phone #
		( )

Email Address

EMPLOYMENT INFORMATION:

Employer Name	Occupation	Employer Phone #

STATISTICS REQUIRED FOR GOVERNMENTAL REPORTING:

☑ Tax Filing Status:
☐ Return Not Filed
☐ Single
☐ Married
☐ Head of Household

Is Head of Household:
☐ Male ☐ Female

☑ All that Apply:
☐ Homeless
☐ Migrant Farm Worker
☐ Language Barrier
☐ None of the Above

☑ Race: (Check all that apply)
☐ White/Caucasian
☐ Black/African American
☐ American Indian/Alaska Native
☐ Hawaiian/Pacific Islander
☐ Asian
☐ Declined to specify

☑ Ethnicity:
☐ Decline to specify
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

ADVANCED DIRECTIVE:

Do you have a living will? ☐ Yes ☐ No Is it on file with your Primary Care Provider? ☐ Yes ☐ No

*****FOR STAFF USE ONLY*****

Portal Enrollment Reviewed: ☐ Yes ☐ No *If No, Reason:* ☐ Patient Already Enrolled ☐ Other: _____
Token Generated: ☐ Yes ☐ No *If No, Reason:* ☐ Patient Already Enrolled ☐ Other: _____
Reason for No Email: ☐ Declined (Refuse) ☐ Deferred (Self-Enroll) ☐ No Email

PHS Staff Name (Print) ***PHS Staff Signature*** ***Date of Signature***

PRIMARY HEALTH SOLUTIONS
PATIENT REGISTRATION/FINANCIAL FORM

Today's Date: Month / Day / Year

PARENT / RESPONSIBLE PARTY (Required for patients less than 18 and whenever the guarantor is not the patient):

Last Name	First Name	MI	Social Security #	Birth Date Month / Day / Year	Relationship

INSURANCE INFORMATION (Please present ALL Insurance Cards and a Picture ID to the receptionist):

Primary Insurance	Policy #	Group #	Effective	Co-Pay $	Policy Holder	Relationship
Secondary Insurance	Policy #	Group #	Effective	Co-Pay $	Policy Holder	Relationship
Tertiary Insurance	Policy #	Group #	Effective	Co-Pay $	Policy Holder	Relationship

HOUSEHOLD INCOME:

It is the policy of Primary Health Solutions to provide essential services to those who have no means, or limited means, to pay for their medical services (Uninsured or Underinsured). Discounts will be based on income and family/household size, only.
Please complete the following information to determine if you or members of your family are eligible for a discount.

**For the purpose of assistance, family/household is defined as: anyone who lives in the same house/address.*

Section (a): Total combined Income for all persons working in the household. **Section (b):** How often you get paid. **Section (c):** Any additional income received in the household. **Section (d):** Total number of people the household income supports.

ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

(a)Total Household Income before Taxes:	**(b) ☑ Frequency:**	**(c) Other Income:**	**(d) Total Number of People Supported by Income:**
$	☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly	**$**	

DOCUMENTATION OF NO INCOME:

If you have reported $0 household income in the section above, please explain how you are meeting your daily needs.

_____

_____

ACKNOWLEDGEMENT & CONSENT:

I understand that to determine eligibility for the sliding fee program, I must provide one of the following: prior year W-2, two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed). If Self-employed, I must submit detail of the most recent three months of income and expenses for the business. Primary Health Solutions may request additional information before the patient named above is approved for a discount.

I agree to inform Primary Health Solutions of any changes in circumstance that may affect the patient's eligibility. Any intentional false or fraudulent information provided will be grounds for denial of services for the patient. I understand the information above must be updated every twelve (12) months, or if there are any changes in family size or household income.

I have received information explaining the Sliding Fee Scale Program and I agree to follow its terms. I understand that any discount I am eligible for, will apply to all services received at any of the Primary Health Solutions practices, but not those services or equipment that are purchased from outside, including reference laboratory testing, medications, and x-ray interpretation by a consulting radiologist, and other such services. If I elect to pay the full fee or do not qualify for a discount, I may receive a bill if all services provided are not covered by the fee paid upfront.

I certify that all information given by me is true. I consent to any services rendered to me or my dependents by the provider. I understand this authorization will also permit the center to release information related to my medical records to other offices to assist in my continuing care. I acknowledge full financial responsibility for services rendered by Primary Health Solutions. I authorize the release of information to my insurance carrier and authorize payment directly to Primary Health Solutions. I have read and fully understand the above.

_____ _____ _____

Patient Name/Responsible Party (Print) ***Signature of Patient/Responsible Party*** ***Date of Signature***

☐ Patient ☐ Parent ☐ Guardian

*****FOR STAFF USE ONLY*****

Income Documents Received: ☐ Yes ☐ No *If No, Reason:* ☐ One Day Slide ☐ Refused ☐ Other: _____

Documents Scanned: ☐ Yes ☐ No *If No, Reason:* _____

Insurance Card Scanned: ☐ Yes ☐ No *If No, Reason:* _____

_____ _____ _____

PHS Staff Name (Print) ***PHS Staff Signature*** ***Date of Signature***