Primary Health Solutions

Primary Health Solutions
Patient Registration and Financial Form

PATIENT INFORMATION

Last Name	First Name	MI	Birth Sex ☐ Female ☐ Male	Social Security #	Birth Date

Patient Billing Address (Responsible Party)	City	State	Zip

Patient Residence (if different)	City	State	Zip

Which contact method do you prefer? Select and complete all that apply.

☐ Cell Phone #	☐ Home Phone #

☐ Email Address

Can we send notifications? *Select all that apply*

☐ Opt Out ☐ Email ☐ Phone ☐ Text ☐ Voicemail

There is some level of risk that information in a regular (unencrypted) text message or email could be read by someone besides you.

Emergency Contact Name	Emergency Contact Relationship

Emergency Contact Phone #	Emergency Contact Email Address

EMPLOYMENT INFORMATION

Employer Name	Occupation	Employer Phone #

REQUIRED STATISTICS

Religion

☐ Christian ☐ Other
☐ Islamic _____
☐ Agnostic
☐ Scientology
☐ Buddhist
☐ Hindu
☐ Unknown
☐ Atheist

Race *(Check all that apply)*

☐ White/Caucasian
☐ Black/African American
☐ American Indian/Alaska Native
☐ Native Hawaiian
☐ Asian
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Other Pacific Islander
☐ Guamanian or Chamorro
☐ Samoan
☐ Decline to Specify

Ethnicity

☐ Hispanic or Latino
☐ Mexican, Mexican American, Chicano
☐ Puerto Rican
☐ Cuban
☐ Not Hispanic or Latino
☐ Decline to Specify

Tax Filing Status

☐ Return not filed
☐ Single ☐ Married
☐ Head of Household

Student Status

☐ Full Time Student
☐ Part Time Student
☐ Not a student

Select all that apply

☐ Veteran
☐ Homeless
☐ Migrant Farm Worker
☐ Language Barrier
☐ None of the Above

Preferred Language

☐ English
☐ Spanish
☐ Nepali
☐ French
☐ Russian
☐ Other _____

Marital Status

☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Life Partner
☐ Other _____

PATIENT INSURANCE INFORMATION

	Policy #	Group #	Date Effective	Policy Holder	Relationship to Pt
Primary Insurance					
Secondary Insurance					
Dental Insurance					

ADVANCED DIRECTIVES

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

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PARENT/GUARDIAN/RESPONSIBLE PARTY *(Required for patients under 18 and whenever the guarantor is not the patient)*

Last Name	First Name	MI	Birth Sex ☐ Female ☐ Male	Social Security #	Birth Date

Address	City	State	Zip

Phone #	Email Address

Tax Filing Status
- ☐ Return not filed
- ☐ Single
- ☐ Married
- ☐ Head of Household

Select all that apply
- ☐ Homeless
- ☐ Migrant Farm Worker
- ☐ Language Barrier

Race *(Check all that apply)*
- ☐ White/Caucasian
- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian
- ☐ Asian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Decline to Specify

Ethnicity
- ☐ Hispanic or Latino
- ☐ Mexican, Mexican American, Chicano
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Not Hispanic or Latino
- ☐ Decline to Specify

HOUSEHOLD INCOME *(All information is kept confidential)*

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 income for patient and/or responsible party and how you are reporting that income.

Section (b): Other Household income and how you are reporting that income.

Section (c): Number of immediate household family members. Immediate family is your husband/wife/partner and your children.

Section (d): Number of non-immediate family household members.

(a) Your Income: ☐ Yearly ☐ Monthly ☐ Bi- Weekly **$**	**(b) Other Household Income:** ☐ Yearly ☐ Monthly ☐ Bi- Weekly **$**	**(c) # of immediate household family members** *(Immediate family = husband/wife/partner and your children)*: ☐ Self ☐ Partner ☐ Children #_____

(d) # of non-immediate family household members: ☐ #_____

\\If.claiming.non_immediate.family?further.documentation.such.as.your.income.tax return.listing.dependents.or.head.of.household.status.may.be.required¡

DOCUMENTATION OF NO INCOME

If.you.have.reported.P6.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 may be asked to 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), etc. 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 circumstances 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 also consent to tests and procedures necessary for infection control. 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