Patients Name:________________________________ DOB:____________

Harbor Health Services, Inc.

New Patient Registration

Today's Date: __________

First Name ________________________________ MI ______ Last Name ____________________________________

Date of Birth ____ Email Address _________________________________

Home Address____
Street *City* *State* *Zip*

Mailing Address if different____
Street *City* *State* *Zip*

Home Phone ____________________ Work Phone ______________________ Other/Cell Phone _________________

Preferred Primary Contact ____ Home _____ Work _____ Other/Cell

The only people who see this information are registration staff, administrators for the health center, and the people involved in quality improvement and oversight. The confidentiality of what you say is protected by law.

How did you hear about our health center? ____

Please choose how you would like us to contact you for appointment reminders:

- ○ Voicemails Yes / No
- ○ Text message Yes / No
- ○ Email Yes / No Email Address________________________

<u>Person to contact in case of emergency:</u>

Name ____ Telephone # _________________________________

Relationship to patient ________________________________ DOB____

<u>Responsible person / (if different from patient):</u>

Last Name ________________________________ MI ______ First Name ____________________________________

Address____Telephone #__________________

Date of Birth__________________ Relationship to patient____

Patients Name:________________________________ DOB:__________

Harbor Health Services, Inc.

New Patient Registration

We would like you to tell us your cultural identity so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care.

(Please select your self-reported cultural identification that best describe your background)

- ○ African (Specify:__________)
- ○ African American
- ○ American
- ○ Asian Indian
- ○ Brazilian
- ○ Cape Verdean
- ○ Caribbean Islander (Specify:__________)
- ○ Chinese
- ○ Columbian
- ○ Cuban
- ○ Dominican
- ○ Filipino
- ○ Guatemalan
- ○ Haitian
- ○ Honduran
- ○ Japanese
- ○ Korean
- ○ Laotian
- ○ Mexican, Mexican American, Chicano
- ○ Middle Eastern (Specify:__________)
- ○ Portuguese
- ○ Puerto Rican
- ○ Russian
- ○ Salvadoran
- ○ Vietnamese
- ○ Other (Specify:__________)
- ○ Unknown/Not Specified

Gender: ☐ Male ☐ Female	**Race: Please select one or more than one** ☐ American Indian / Alaskan ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White	**Are you a veteran?** ☐ Yes ☐ No
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other:____________	**Highest Level of Education:** US / OUS ☐ No Schooling ☐ Not a high school graduate ☐ High School / GED ☐ Other: __________	**Are you a migrant worker?** (Agricultural) ☐ Yes ☐ No ☐ Seasonal
What is your ethnicity? ☐ Hispanic ☐ Non-Hispanic ☐ Decline to answer ☐ Unknown ☐ (Specify:____________)	**Primary Language:** ______________________ **Do you need an interpreter?** ☐ Yes ☐ No	**Homeless?** ☐ Yes ☐ No

Patients Name:_______________________________________ DOB:_____________

Harbor Health Services, Inc.

Permission to Photograph

I agree that Harbor Health Services, Inc. (HHSI) may take a digital photo of me.

I understand that:

- The photo will be stored permanently in my medical record.
- The photo will be used to identify me when I come here for care.
- The photo will be stored securely to protect my privacy.
- The photo will **NOT** be used outside of HHSI, unless I (or my legal representative) give my permission in writing.
- HHSI will own the photo. I can look at the photo, or get copies, if I (or my legal representatives) sign a release form

Patient / Guarantor Signature ____ **Date**__________________________

Relationship to Patient ____ **Date** __________________________

HHSI Staff Signature____ **Patient Refused Picture** _________

Patient's Acknowledgement of Receipt of

Harbor Health Services, Inc.

Notice of Privacy Practices

I have received Harbor Health Services, Inc.'s Notice of Privacy Practices.

Patient / Guarantor Signature ____ **Date**_______________________

Relationship to Patient ____ **Date** _______________________

HHSI Staff Signature____ **Patient Refused To Sign** ______

Patients Name:_________________________________ DOB:____________

Harbor Health Services, Inc.

Statement of Income

Patient Name: _____________________

Address: ________________________

DOB: __________________________

Phone: _________________________

Email: _________________________

All patients must complete the form below and update annually. As a federally qualified health center, we are required to obtain the following information from our patients annually. The only people who see this information are registration staff, administrators for the health center and the people involved in quality improvement and oversight. The confidentiality of what you say is protected by law.

Family Size

Who is the primary head of this patient's household? ____

Relationship to patient: ____

How many people are in your family? ____

Income

Counting yourself, your spouse and all dependent children (those 18 yrs old or younger who are still claimed as dependents on your Federal Tax Return) what is your gross income (income before taxes) for your family?

$______________________ Select one:

- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Annually

Patient / Guarantor Signature _____________________________________ **Date**______________________

Relationship to Patient ____ **Date** ______________________

HHSI Staff Signature____ **Patient Refused To Disclose** _____

Patients Name:________________________________ DOB:____________

Harbor Health Services, Inc.

MEDICAL INSURANCE INFORMATION

Name of Insurance ___________________________ Member ID number ___________________________

Name of Subscriber __________________________ Group # ___________________________________

Relationship to Patient: □ Parent/Guardian □ Spouse □ Partner □ Self DOB__________

DENTAL INSURANCE INFORMATION

Name of Insurance ___________________________ Member ID number ___________________________

Name of Subscriber ___________________________ Group # __________________________________

Relationship to Patient: □ Parent/Guardian □ Spouse □ Partner □ Self DOB__________

<u>Authorization and Consent</u>

1. I request care from Harbor Health Services or one of their affiliates for treatment of my medical/dental or mental health condition, and/or for the routine or intensive care of my new born baby. This care may include medical tests, exams or other treatments that are needed for my condition. I agree to this.
2. This signature authorizes us to submit the required information regarding your medical services to your Health Care Carrier for payment. The authorization also provides the payment of benefits directly to the provider of your services.
3. I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical /government benefits to the physician/supplier of the service described on this claim.
4. I understand any balances after the insurance carrier payment or **services not reimbursed by my insurance carrier** are my responsibility for prompt payment. If I do not produce **or confirm that a valid referral was obtained** as required by my insurance carrier that I would be responsible for the nonpayment of any charges.

<u>Insurance and Payment Information:</u>

Harbor Health Affiliates receive payment for patient care from insurance companies, Medicare, and/or other third party programs.

5. I agree to have my insurance company, Medicare, or other third party payment program make payments directly to Harbor Health and/or its Affiliates
6. I agree to let my doctor(s) and/or the Harbor Health submit claims and required treatment information to my insurance company, Medicare, or other third party payment program for my care, and receive payments directly.
7. I understand that I must pay all charges, co-payments, and deductibles that are not covered by my insurance company, Medicare, or third party payment program.

Permission to Communicate with Your Primary Care Physician and/or Other Community Care Providers: In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician, other community care providers and to your insurance company. These communications may include information about your medical/dental treatment and mental health or substance abuse treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of your care. Many insurance companies require us to document whether or not you will allow your clinician to communicate with your primary care physician and/or Health Insurance Company.

Patient / Guarantor Signature ____________________________________ **Date**____________________

Relationship to Patient ____ **Date** ____________________

HHSI Staff Signature____ **Patient Refused To Sign** ______