summit community
CARE CLINIC

PATIENT REGISTRATION

Patient's Last Name:	First Name:	Middle Initial:	Date of Birth:	Sex at Birth: M F	Are you a Veteran? Y N

Email Address:	Social Security No:

Mailing Address:	Apt/Unit #	City:	State:	Zip Code:
Physical Address:	**Apt/Unit #**	**City:**	**State:**	**Zip Code:**

Please mark the check box for your preferred phone number:

☐ Cell Phone:_____ ☐ Home Phone: _____ ☐ Other Phone: _____

Insurance: ☐ I do not have health insurance

	Primary Medical/Behavioral Health	Secondary Medical/Behavioral Health	Dental
Name			
ID #			
Group #			

Pharmacy Name, City, State, Zip Code:

Name: _____

Address: _____

_____

Phone: _____

Employment status:

Employed Unemployed Retired

Student Self-employed Seasonal

Student Child

Migratory/ Seasonal agricultural worker

Parent or Guardian or REsponsible Party for those under 18 years old:

Name: _____

Address: _____

_____

Phone #: _____

Date of Birth: _____

Relationship: Spouse Child Other

HOUSEHOLD INCOME AND FAMILY SIZE

Estimated Household Income (before taxes)

☐ Weekly _____ ☐ Monthly _____ ☐ Annual _____

Number of financial dependents living in your household (including yourself)

PLEASE CIRCLE:

RACE (CIRCLE ONE)	PRIMARY LANGUAGE (CIRCLE ONE)	ETHNICITY (CIRCLE ONE)	GENDER IDENTITY (CIRCLE ONE)	SEXUAL ORIENTATION (CIRCLE ONE)
AMERICAN INDIAN OR ALASKA NATIVE	AMERICAN SIGN LANGUAGE	HISPANIC OR LATINO	CHOOSE NOT TO DISCLOSE	BISEXUAL
ASIAN	ENGLISH	NOT HISPANIC OR LATINO	FEMALE	CHOOSE NOT TO DISCLOSE
BLACK OR AFRICAN AMERICAN	FRENCH	NOT PROVIDED	GENDERQUEER	DO NOT KNOW
NATIVE HAWAIIAN	SPANISH		MALE	LESBIAN OR GAY
OTHER PACIFIC ISLANDER	OTHER:		OTHER	SOMETHING ELSE
WHITE			TRANSGENDER WOMAN/TRANSGENDER FEMALE	STRAIGHT OR HETEROSEXUAL
			TRANSGENDER MAN/TRANSGENDER MALE	

IN CASE OF EMERGENCY

Please tell us who to contact in case of an emergency (parent or guardian if patient is under 18). An emergency would be severe bleeding, unconsciousness, accident or a condition requiring transport or hospitalization. Family planning services DO NOT require parental permission; however, in an emergency situation, if you are under 18 years of age, we will notify a parent or guardian.

Does the person listed below know that you are receiving services here? ☐ Y ☐ N

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____ PHONE # _____

PATIENT REGISTRATION FORM, continued

Patient's Last Name: First Name:	Date of Birth:

CONSENTS

In order to establish you as a patient of Summit Community Care Clinic (SCCC) , please review each of the statements below, initial them and sign at the end that you consent to SCCC's policies. Copies of all policies are provided to you in printed format and may also be found on

ACKNOWLEDGEMENT AND RECEIPT OF PRIVACY PRACTICES:

I acknowledge receiving and reading a complete copy of the Notice of Privacy Practices of SCCC. I further acknowledge that, as of today's date, I have no questions regarding the Notice of Privacy Practices. Initials _____

CONSENT FOR HEALTHCARE:

I acknowledge receiving and reading a complete copy of the Treatment Consent , Consent to Participate in Telehealth for Medical, Dental, and Behavioral Health. I voluntarily consent to Medical, Dental or Behavioral Health treatment, laboratory procedures, administration of medication, and other health services that may be ordered by a Medical, Dental and Behavioral Health Providers participating in my care.

Initials _____

ACKNOWLEDGEMENT AND RECEIPT OF FINANCIAL AGREEMENT:

I acknowledge receiving and reading a complete copy of the Financial Agreement. I hereby authorize payment to SCCC of insurance benefits. I accept responsibility for any unpaid balances left on my account regardless of the amount of insurance coverage. I am responsible for any charg- es of service and agree to pay for services at the time of service. Initials _____

NO SHOW POLICY:

I acknowledge receiving and reading a complete copy of the No Show Policy. I further acknowledge that, as of today's date, I have no questions regarding the No Show Policy. Initials _____

I UNDERSTAND that my Personal Health Information (PHI) will be released only with my authorized signature on a records release form. Many insurance companies may require release of PHI in order to pay claims. If you choose not to release confidential PHI and the insurance company will not pay the claim for those services, you will be liable for those charges. I understand that my PHI will be shared via a Health Information Exchange (HIE) to ensure continuity of care between hospitals, specialty medical groups and Providers. Please inform staff if you do not want this. Initials _____

I AUTHORIZE SCCC to contact me via patient portal or phone with medical information and for overdue care reminders. I understand that charges from my cell phone carrier may apply. Initials _____

I UNDERSTAND the risks of using email and agree that email messages may include the protected health information about me, or the patient named on this registration. I understand that email should not be used for urgen or emergent situations. Initials _____

I AUTHORIZE SCCC throught its vendor RavePoint to contact me by SMS text message to serve me better. I understand that message/ data rates apply and I could receive up to 10 messages per month. I may contact SCCC if I choose to not receive text messages. Initials _____

I certify,

that the above information is true, accurate, and complete to the best of my knowledge, (incorrect or false information will result in termination of services). I permit Summit Community Care Clinic representatives to contact any necessary person or agency to verify this information. If further information is needed, I must furnish it within 30 days.

If you are completing this form for another person, what is your relationship to that person?

Your name _____ **Relationship** _____ **Phone #** _____

PATIENT SIGNATURE **X** _____ **DATE** _____