Sierra Family Health Center
Caring for your as family

PATIENT REGISTRATION

Please provide us with your insurance card and valid ID

Last Name_____ First Name_____ Middle Initial_____

Date of Birth_____Social Security#_____-_____-_____ Gender at Birth ___Male ___Female

Mailing Address_____City_____

State_____Zip Code_____Email Address_____

Physical Address (if different)_____

City_____State_____ZipCode_____

Telephone: Home _____ Cell _____ Work_____

Primary Phone: ___ Home ___ Cell ___ Work Preferred Time of Call: ___ Morning ___ Afternoon ___ Evening

Length of Message: ___ Brief ___ Extended On Which Phone? ___ Home ___ Cell ___ Work

Preferred Language: ___ English ___ Other: _____ Interpreter needed? ____Yes ____No

Would you like access to your medical provider team and (limited) medical records online? ____Yes ____No

If yes, please see Your Patient Portal information sheet included in this packet.

Which pharmacy do you use (Please see our Preferred Pharmacy information)?

Pharmacy Name _____ City _____

Parent Information If Patient Is Under 18:

Parent/Legal Guardian _____Birthdate_____

Contact Phone_____Email:_____

Type of Parent(s) ____Biological _____Adoptive ____Foster ____ Other _____

Parent/Legal Guardian _____Birthdate_____

Contact Phone_____Email:_____

Type of Parent(s) ____Biological _____Adoptive ____Foster ____ Other _____

Emergency Contact:

Let us know who to call if there's an emergency. This person also needs to be listed on the HIPAA authorization form.

Name_____Relationship_____

Cell Phone_____Home_____

Financial and Insurance Information:

Here we need the details about the account holder (the person that will be paying for services).

____Medicare ___Medicare Supplemental _____

____Medi-Cal (type): _____

____Commercial (type):_____

___Self-Pay

Patients may be eligible to receive a discount through the sliding fee discount program. Discounts are based on family size and household income. Our staff can help you with questions regarding our health care and dental plans.

Account Holder or Person Paying:

Co-pays and outstanding balances are due at the time of service. Insurance is billed after the visit. Sometimes there is still money owed. Who should we send statements to?

_____Patient _____Other

If you marked Other, please let us know:

Last Name_____First Name_____Initial_____

Relationship to Patient_____

Address_____City _____

State_____ZipCode_____Email Address)_____

Cell Phone_____Home_____Work_____

Consent

In order to provide treatment, coordination of clinical care, bill your insurance, or release information required by your insurance carrier, we must receive your consent by initialing the areas indicated and by providing your signature below.

Consent for Treatment: I hereby authorize and consent to procedures necessary for diagnosis and treatment for myself (or child/dependent stated above) while a patient at the Sierra Family Health Center. **_____ (initials)**

Release of Information: I authorize the release of information collected by the center necessary for a coordination of clinical care and to process billing claims related to my care (or child/dependent stated above). **_____ (initials)**

Assignment of Benefits: I authorize payment of medical benefits to Sierra Family Health Center for professional services rendered. **_____ (initials)**

Your signature below indicates you have read, understand and agree to the payment policy, and consents.

Signed: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

Additional Information—For Purposes of Grant Funding

The information you provide can help us recognize patients who may qualify for specially funded programs or services.

Marital Status:

- ☐ Divorced
- ☐ Married
- ☐ Partner
- ☐ Single
- ☐ Widowed
- ☐ Legally Separated
- ☐ Other _____

Sexual Orientation (For Patients Age 18 and Older):

☐ Heterosexual (Straight - not lesbian or gay) ☐ Homosexual (Lesbian or Gay) ☐ Bisexual

☐ Choose not to disclose ☐ Do not know ☐ Something Else Describe:_____

Gender you identify with:

- ☐ Female ☐ Male ☐ Choose to not disclose
- ☐ Transgender Male (Female-to-Male) Date of Transition: _____
- ☐ Transgender Female (Male-to-Female), Date of Transition: _____
- ☐ Gender queer, neither exclusively male nor female
- ☐ Additional gender category or other, please specify:_____

Race? Check all that Apply

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Other Race
- ☐ Black/African American
- ☐ White
- ☐ Declined to Specify

Ethnicity: □ Hispanic/Latino: □ Non-Hispanic/Latino □ Unreported /Refused to report

Have you served in the military? ____Yes ____No

In the last 2 years, have you or a member of your family lived away from home in order to work in any type of agriculture (farm work)? ____Yes ___No

Total number of people living in household: _____

Approximate total yearly income earned by family household: $_____

Would you consider yourself homeless at any time in the last 12 months? _____Yes _____No

If Yes, where:

- ☐ In your car
- ☐ On the street
- ☐ In a shelter
- ☐ With another family
- ☐ In a hotel
- ☐ Other_____

Where did you hear about our services?

- ☐ Family member
- ☐ Friend who loves the service!
- ☐ Newspaper/magazine
- ☐ Radio
- ☐ Social Media
- ☐ Insurance Company
- ☐ Flyer
- ☐ County Agency

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YOUR PRIVACY OPTIONS

Receipt of Privacy Practices & HIPAA Authorization

This form is to help us know whether you would like us to share information with the people in your life. Telling SFHC how you want to share information is called HIPAA Authorization and it's from the Health Insurance Portability and Accountability Act (HIPAA). This form also helps us to know that we have asked to give you our privacy practices. You are welcome to have a copy of our privacy practices.

Patient Information

Last Name: _____ First Name:_____ Middle Initial: ____

Nickname: _____ Date of Birth: _____

Name of Parent, Legal Guardian, or Conservator: (*Only if any of these apply to you.)*

_____

Messages: You allow SFHC to leave voice messages at the phone numbers you've given us. You can opt out of this service at any time.

Who to Share With: Please tell us with whom we can share, or release, information.

If you do not want ANYTHING told to or shared with ANYONE check here: ☐

Person #1: _____Relationship:_____

If the patient is under 18 years old, this person is allowed to give permission and make decisions for:

☐ Medical care ☐ Immunizations

Person #2: _____Relationship:_____

If the patient is under 18 years old, this person is allowed to give permission and make decisions for:

☐ Medical care ☐ Immunizations

Person #3: _____Relationship:_____

If the patient is under 18 years old, this person is allowed to give permission and make decisions for:

☐ Medical care ☐ Immunizations

Patient Sign: _____ **Date:** _____

Parent/Guardian/Conservator Sign: _____ **Date**_____

I have been asked if I want a copy of SFHC's Notice of Privacy Practices. _____ (initial)

This approval ends one year from the date signed or updated in writing.

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FINANCIAL POLICY

For Medical, Dental and Behavioral Health Services & Fees

All of us at Sierra Family Health Center believe it is essential for you, the patient, to understand the Center's expectations regarding the financial aspect of your visit.

Required at check-in:

1. Verify Personal Contact Information
2. Present Current Copy of Insurance Card (We ask for a copy of an ID card or license to help protect you from identify theft.)
3. Present Current Picture ID
4. Payment of any Outstanding Balance
5. Payment of Today's Visit (Copays, coinsurance or deductible amounts and non-covered fees as identified by your insurance company are due at the time of service).
6. We take cash, check or credit card.

Insurance Billing:

Sierra Family Health Center is a participating provider or considered in-network with a few plans; you can find out if the Center is with your plan by contacting your insurance company.

Learn what services and clinicians are covered before your visit by calling your insurance benefits department.

Sierra Family Health Center will bill your insurance company for services provided. Ultimately, you are responsible for any charges not paid by your insurance carrier. In order for us to accurately and correctly bill your insurance company, we require for you to provide us with current information at every visit. This includes an up to date copy of your insurance card and a completed patient information sheet.

In the event that we cannot validate active coverage with your insurance carrier, your account will be considered self-pay. In such cases, we will collect payment at time of service and refund any amounts subsequently collected from your carrier.

If you are insured by a non-participating insurance carrier, or if Sierra Family Health Center is not the preferred provider listed by your carrier, we will expect payment from you at time of service and it will be your responsibility to submit any claims to your insurance company for direct reimbursement to you. We will provide you with the appropriate information to assist you in this process.

If our clinicians or services are not listed in your plan's network (on their list of clinicians or services they have a contract with):

- ✓ You may have to pay for part of, or the entire bill.
- ✓ Your insurance might send the payment for you to bring and pay at your SFMC visit.

Remember:

1. You must bring your insurance card to every visit. We will need to copy both sides.
2. If you have insurance, we will send them the bill.
3. If the insurance does not cover the fees, you will need to pay. If we get a payment from your insurance after you pay, we will refund what is due to you.
4. If you are referred to another provider or other services, any bills or fees you get from them will be between you and them. They may bill differently than we do at SFHC.
5. Diagnostic tests are billed separately.
6. Outstanding balances over 90 days may be referred to collections and you may be required to bring your balance current before your next appointment.

If your insurance does not cover part of your fee:

You might qualify for our sliding fee discount program for the things that are not covered. Medical and Dental have different rules.

If you have questions about your bill or fees our Billing Team is happy to help! Call us at (530) 292 3478 Ext 219.

I have read and understand the details of the SCHC Financial Policy.

Patient Name: _____ **Date:** _____

Sign (Patient or Account Holder)**:** _____