RURAL HEALTH SERVICES, INC.

PATIENT REGISTRATION FORM

PERSONAL INFORMATION

Full Name :

Date of Birth : M M / D D / Y Y

Social Security : - -

Home Phone: - -

Cell Phone : - -

Other :

Email :

Address :

City:

State:

Zip:

Emergency Contact:

Phone: - -

Relationship:

Preferred Pharmacy :

Location:

HELP US GET TO KNOW YOU BETTER

Gender at birth : Male Female

Gender Identification : Male Female Transgender Male (Female to Male) Transgender Female (Male to Female) Gender Queer Other Prefer not to say

Sexual Orientation : Straight/Heterosexual Lesbian/Gay/Homosexual Bisexual Something Else Prefer not to say

Marital Status: Single Married Partner Separated Divorced Widowed Unknown

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Race (Check All That Apply) : American Indian/Alaskan Native Asian Black/African American Native Hawaiian Other Pacific Islander White Prefer not to say Multi-races _____

Preferred Language: English Spanish Other _____ Translator needed? Yes No

Are you Homeless? Yes No If yes, you are Doubling up Shelter Street Transitional Housing Other

Are you a Veteran? Yes No

Are you an Agricultural Worker? Yes No If yes, you are Migrant Seasonal

FAMILY SERVICES

Please help us extend our services to those in need by providing information about you and your family below:

Family Size: 1 2 3 4 5 6 7 8 9 or more

Income Level: $

SCHIEx (South Carolina Health Information Exchange)

Enables physicians across SC to view the patient information they need to make well informed decisions. By providing real-time access to life-saving data, SCHIEx is improving quality, safety, and efficiency of health care delivery in our state.

SCHIEx Consent: Yes No

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PROTECTED HEALTH INFORMATION

Authorization of Protected Health Information for discussion of care and treatment and/or payment to the person(s) specified below. This does not give the listed person(s) permission to make health care decisions for the patient. Rural Health Services, Inc. (RHS) will not release Protected Health Information to anyone not listed except for when it is reasonable to assume that the patient does not object, such as when the patient brings an individual into the exam room when treatment is discussed. (45CFR.164.502(F) & 64.502(G).

☐ **I hereby authorize release of my Protected Health Information for discussion of my care and treatment and/or payment to the person(s) specified below.**

☐ **I do not hereby authorize release of my Protected Health Information for discussion of my care and treatment and/or payment to anyone.**

1. _____
   Name Relationship Phone

2. _____
   Name Relationship Phone

3. _____
   Name Relationship Phone

PATIENT PORTAL ACCESS

The patient portal provides electronic access to view parts of medical records, scheduled appointments, send questions to the medical staff, etc. The patient portal is securely maintained, and password protected.

Patient Portal Access: ☐ **Yes** ☐ **No**

GUARANTOR

Full Name :

Date of Birth : M M / D D / Y Y

Social Security : - -

Phone: -

Relationship to Patient:

Address :

City:

State:

Zip:

Insurance Information:

Primary Insurance Company:

Policy #:

Secondary Insurance Company:

Policy #:

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PATIENT CONSENT

By signing below, I consent to the following:

Confidentiality:

I am aware that information about treatment is considered confidential and will be used in a manner consistent with proper professional conduct and will only be released to outside sources under applicable state and federal law statues and regulations or when ordered by court.

Financial Agreement:

I agree to pay RHS for services rendered, I acknowledge that payment is due at the time of service and payable upon receipt of a billing statement. This includes all co-pay amounts, deductibles, and sliding fee co-pays. If payment has not be received within 120 days from the date of service or if failure to meet requirements of Financial Agreement are not met, the account will be sent to collections. Payment agreements may be made with the billing department if accounts cannot be paid in full at the time of service.

Insurance Billing Agreement

RHS will file the insurance claim. The responsibility for the prompt payment of the carrier remains with the Patient. It is not RHS's policy to contact out-of-network carriers to establish what they have paid of why they have paid less than originally indicated.

I request that payment of authorized insurance benefits be made to me or on my behalf to the providers(s) of RHS, for services rendered by the party who accepts assignment. Regulations pertaining to Medicare assignments of benefits apply. I authorize any holder of my Protected Health Information to be released to the Social Security Administration and Health Care Financing Administrations; its intermediaries; or carries, any information needed for insurance claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or to the party who accepts assignment. I understand billing information relating to services rendered could be released to my insurance provider for payment of services received.

RHS does not file liability insurance, such as motor vehicle or third-party coverage. We will provide upon request information needed for you to file your claim for third-party coverage.

Workers Compensation Claims:

Claims will be sent to the employer for processing by their compensation carrier. It will be the Patient's responsibility to pay any portion of the claim that is denied or determined not to be related or if the Patient fails to provide adequate information to file this claim.

Consent for Treatment (ADULT):

I consent to receive any treatment or procedure deemed necessary by the professional staff at RHS. I understand and will adhere to all the preceding statements.

Consent for Treatment (CHILD or INCAPACITATED ADULT):

I hereby state that I am the parent, primary legal custodian, or joint legal custodian of the patient being presented today for treatment. I am giving consent as guardian for any treatment or procedure deemed necessary by the professional staff at RHS. I understand and will adhere to all the preceding statements.

I have been given the opportunity to receive a copy of the Rural Health Services, Inc. Notice of Privacy Practices

This health center received HHS funding and has Federal Public Health Service (PHS) deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals

Print Name of Patient: _____

Patient/Legal Guardian Signature: _____ **Date:** _____

Assistance with completion of form provided by:

☐ **RHS Staff** _____ **or** ☐ **Other** _____