Patient Registration

☐ I need a hearing interpreter ☐ I need a language interpreter

Patient Info - Preferred Name: Date:

First Name | Middle Initial | Last Name

Date of Birth | Social Security# | Occupation

Address | Apt# | PO Box

City | State | Zip Code | County

Primary Phone | Secondary Phone | Email

Emergency contact (not living in your household):

First Name | Last Name | Phone# | Relationship to patient

Does the patient reside in a nursing home or residential care facility ?

☐ Yes ☐ No If Yes, Where? Phone#

Access Family Care participates in federal programs that require us to request the following:

Race
- ☐ White
- ☐ Asian
- ☐ American Indian/Alaska native
- ☐ Black/African American
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Decline to answer/Unknown

Ethnicity
- ☐ Not Hispanic/Latino
- ☐ Hispanic/Latino
- ☐ Decline to answer/Unknown

Preferred Language
- ☐ English
- ☐ Spanish
- ☐ Other_____

Marital Status
- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Separated
- ☐ Child

Sex Assigned at Birth
- ☐ Male
- ☐ Female

Sexual Orientation
- ☐ Lesbian,Gay/Homosexual
- ☐ Straight/Heterosexual
- ☐ Bisexual
- ☐ Don't Know
- ☐ Something else
- ☐ Choose not to disclose

Gender Identity
- ☐ Male
- ☐ Female
- ☐ Transgender Man/Male/Masculine
- ☐ Transgender Woman/Female/Feminine
- ☐ Other:_____
- ☐ Choose not to disclose

Estimated Annual Household Income:

$_____

☐ Choose not to disclose

Adults in Household _____

Children in Household _____

Are you an agricultural worker ☐ Yes ☐ No

Veteran Status ☐ Not a Veteran ☐ Veteran

Homeless? ☐ Yes ☐ No

Guarantor -person responsible for payment (Complete only if responsible party is not the patient)

First Name | Middle Initial | Last Name

Date of Birth | Social Security# | Employer

Address (If different from the patient) | PO Box

City | State | Zip | Email

Primary Phone | Relationship to patient

Insurance: ☐ Medicaid ☐ Medicare ☐ Commercial ☐ Other_____

CONSENT FORM

Patient Name: Patient Date of birth: Date:

Consent for additional release of information (by phone, mail, or in person)

I give my permission to discuss with the individual that I have listed:

☐ Any aspect of health care ☐ Health information only ☐ Financial information only

Name	Relationship	Phone#	Name	Relationship	Phone#
Name	Relationship	Phone#	Name	Relationship	Phone#

Consent to Treat Minor Patient for Medical or Dental Treatment

☐ I, _____am the parent of the patient and authorize the following designated individuals to consent for ☐ Medical ☐ Dental treatment for my child_____. In the event of my absence at the time of injury, illness, or routine scheduled care, I also authorize the below named person(s)to make decisions involving my child's care and to sign necessary documents should my child require hospitalization in case of emergency. I(we) accept financial responsibility for all charges related to any medical/dental treatment or hospitalization rendered by reason of this authorization. This consent does not apply to dental procedures that require Extraction, Nitrous Oxide, or Endodontic treatment(Root Canals). A parent or legal guardian must be present for these procedures. This authorization shall be in effect for 1 year or until_____.

☐ I,_____affirm that I am the step-parent of the patient, am married to the natural parent and live with the natural parent and child, and am able to consent for the child's medical/dental treatment.

Appointed Agent/Relationship	Phone#	Appointed Agent/Relationship	Phone#
Appointed Agent/Relationship	Phone#	Appointed Agent/Relationship	Phone#

Consent for Treatment and Financial Responsibility

Please initial each line:

_____ I give my consent as the patient or primary legal custodian or joint legal custodian of the patient for any treatment or procedure deemed necessary by the professional staff of ACCESS Family Care including but not limited to Medical, Dental, and Behavioral Health providers.

_____ I understand that this treatment may include x-rays and/or lab work. I understand that an emergency dental visit may consist of a diagnosis of the condition and treatment necessary to relieve discomfort, however, final treatment may require additional visits.

_____ I give permission for ACCESS Family care to furnish any information needed for my or the patient's billing and treatment.

_____ I give permission for ACCESS Family Care to view my medication history in the electronic prescribing system in order to provide my prescriptions safely.

_____ I agree to be financially responsible for all charges. I understand payment in full is expected at the time of service.

_____ I request that payment of Medicare, Medicaid, or other insurance company benefits made on my behalf or that of the patient's to be assigned to ACCESS Family Care.

_____ I have received a copy of the ACCESS Family Care Patient Rights. I understand it is my responsibility to read and follow the information contained in this notice.

_____ I have received a copy of the Notice of Privacy Practices. I understand that it is my responsibility to read this notice and ask any questions that I may have.

_____ I have received a copy of the ACCESS Family Care No-Show Patient Agreement. I understand that attendance issues may cause me to be dismissed as a patient with ACCESS Family Care and I agree it is my responsibility to follow this policy.

_____ I agree that my consent is valid as long as I am a patient of ACCESS Family Care.

Final Signature (Applies to all consents)

X

Signature of Responsible Party/legal guardian Date Signature of ACCESS Family Care Staff

ACCESS FAMILY CARE

APPLICATION FOR FINANCIAL ASSISTANCE

SECTION I

(Patient First Name) **(Middle Initial)** **(Last Name)** **Birth Date(mm/dd/yyyy)**

SECTION II HOUSEHOLD INFORMATION

Please list all dependents that this income supports.

**Adults listed below with zero income must provide required documentation (except for your spouse/domestic partner and dependents).*

Name	Age	Relationship to Applicant *(Son, daughter, friend, spouse, etc.…)*	Income Amount (*gross pay before taxes)* *(Wages, Social Security, etc.…)*	How often are you paid? *(Weekly, Bi-weekly, Monthly, Bi-Monthly)*
1		*Self*		
2				
3				
4				
5				
6				
7				

**Please include income documentation for each ADULT listed above.*

SECTION III INSURANCE

Do you have medical/dental insurance? ☐ Yes ☐ No

If YES, Please provide a copy of the front and back of your insurance card(s) to the front desk.

SECTION IV ZERO INCOME DOCUMENTATION

You must provide ONE of the options listed below for Zero income documentation:

A. Notarized Document: You can obtain a document of ZERO income from your local clinic to have notarized.

*Adults (18 years or over) other than spouse/domestic partner or dependents, who live in the home are also required to provide a notarized letter stating that you provide for their basic needs as stated above.

*By providing this information, you are giving us permission to contact this person for verification of the zero income status.

SECTION V APPLICANT AFFIDAVIT

Person completing the application? ☐ **Patient** ☐ **Parent/Guardian** ***(if the patient is a dependent, the guardian must sign)***

I certify that the information on this application is true and accurate. I understand that it is my responsibility to complete the application and provide the required proof of income documentation in order to apply for discounted services. I understand that **1.)** my self-declared income is only valid for a maximum one month, **2)** I can only self-declare once every 12 months, **3.)** I will need to bring proof of income for the sliding discount to cover any other service beyond the first month, **4.)** I have two months from my initial application date to provide the required income documentation to cover any other services beyond the first month, **5.)** this application and any discount that I may qualify for apply only to the household members listed on this application, and **6.)** falsifying information or documentation on this application will result in my application being denied and any applicable discounts received under false pretenses will be revoked and I will be responsible for all charges. I agree to inform Access Family Care if my financial situation changes significantly.

Signature **Date**

For Office Use Only

Self-Declared Sliding Fee Information	**12 Month Sliding Fee Information**
Expiration Date: Chart Number:	Starting Date: End Date:
Number of Household Members:	Number of Household Members:
Total Estimated Gross Income:	Total Gross Income:
Information entered in chart, including pop-up? Yes No	Information entered in chart, including pop-up? Yes No
Approved Sliding Fee Discount: 1 2 3 4 5 6	Approved Sliding Fee Discount: 1 2 3 4 5 6
Completed By:	Completed By:

Medical History

Patient Name (First, MI, Last) | Patient Date of Birth | Date

Occupation | Employer | Marital Status | Physician name

Reason for visit today: | Are you in pain? ☐ Yes ☐ No

Personal Medical History (Please check all that apply):

☐ ADD/ADHD	☐ Coronary Artery Disease	☐ Chemotherapy/Radiation	☐ Thyroid Disease
☐ Anxiety	☐ Heart Attack	☐ Radiation to head/neck	☐ Cold sores/fever blister
☐ Autism/Asperger's	☐ Heart Murmur/Irregular heart beat	☐ Trauma to head/neck	☐ Hepatitis
☐ Bipolar Disorder	☐ Heart trouble/disease	☐ Vision problems	☐ Herpes
☐ Cognitively/ Developmentally Disabled	☐ High Blood Pressure	☐ Migraines	☐ HIV
☐ Depression	☐ High Cholesterol	☐ Malignant Hyperthermia	☐ MRSA infection
☐ Psychiatric Care	☐ History of endocarditis	☐ Hearing problems	☐ Sexually Transmitted Diseases
☐ Anemia	☐ Mitral valve prolapse	☐ Dizziness/Fainting	☐ Tuberculosis
☐ Blood Clots	☐ COPD	☐ Convulsions/ Epilepsy/Seizure Disorder	☐ Chronic abdominal issues
☐ Bruise easily/excessive bleeding	☐ Stroke	☐ Cerebral Palsy	☐ Gallbladder disease
☐ Artificial heart valve	☐ Aneurysm	☐ Cortisone/Steroid medicine	☐ Heartburn
☐ Atrial Fibrillation	☐ Kidney Disease	☐ Diabetes	☐ Liver disease
☐ Chest Pain	☐ Cancer Type:	☐ Osteoporosis	☐ Stomach Ulcer
		☐ Taken or taking bone density medication	☐ Other: (list below)

Surgical History (Please check all that apply and list the date):

☐ Angioplasty/ Cardiac bypass Date:	☐ Pacemaker Date:	☐ History of general anesthesia problems Date:	☐ Joint replacement Type: Date:
☐ Heart stent Date:	☐ Other heart surgery Type: Date:	☐ Appendectomy Date:	☐ Ear, Nose, Throat Type: Date:
☐ Heart valve Date:	☐ Vascular Surgery Date:	☐ Hysterectomy Date:	☐ Gall bladder Date:

Please list any additional surgeries and dates:

List any recent hospitalizations including reason and date:

Would you like information about creating an Advanced Directive? ☐ Yes ☐ No

Medical and Dental History

Patient Name | Patient Date of Birth | Date

Medications/Herbal supplements	☐ **No Medications**
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Allergies	☐ **No Known Allergies**
1.	5.
2.	6.
3.	7.
4.	8.

Family History -Check if your blood relatives have had any of the following:

☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Depression/Suicide

☐ Cholesterol ☐ Bleeding/Clotting ☐ Asthma/COPD ☐ Mental health issues

☐ High Blood Pressure ☐ Diabetes ☐ Alcoholism ☐ Inherited disorders

☐ Other: (Please list)

Social History

Do you use tobacco? ☐ Yes ☐ No Type: Amount/day: How long? Year quit:

Do you drink alcohol? ☐ Yes ☐ No How many drinks per week?

Have you ever used illegal drugs? ☐ No ☐ Yes, used in the past ☐ Yes, currently use

Women's Health History (Dental patients only need to answer questions indicated with *)

Please list the number of: Pregnancies: Live deliveries: Live Children:

Miscarriages: Abortions:

Are you Menopausal/Post-Menopausal? ☐ Yes ☐ No If yes, please provide the age of onset: _____

Date of last menstrual period: _____ Date of last mammogram:_____

Date of last pap smear: _____ Result of pap smear? ☐ Normal ☐ Abnormal

*Are you currently pregnant? ☐ Yes ☐ No Due date? * Are you currently nursing? ☐ Yes ☐ No

Birth/Pediatric History

Maternal illness/complications? ☐ Yes ☐ No Stayed in NICU? ☐ Yes ☐ No

Premature birth? ☐ Yes ☐ No If yes, how early?_____ Feeding History: ☐ Breast ☐ Bottle ☐ Both

Birth Weight lbs. oz. Immunizations up to date? ☐ Yes ☐ No

I certify that to the best of my knowledge, the questions on this form have been answered accurately and that providing false or incorrect information can be detrimental to my(or patient's)health. I understand it is my responsibility to inform the medical office of any changes to my health or medical history. I will not hold my physician or any member of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

PRINT NAME | Signature | Date

No-Show Patient Policy Agreement

The goal of ACCESS Family Care is to assure that our patients have access to high quality medical and dental care when they need it. The purpose of this agreement is to inform you of requirements which have been established regarding your appointments for care at ACCESS medical and dental clinics as follows:

- **You must provide us with a working telephone number, and you must inform us if that number changes.**

- **Reminder of appointment-Although you are ultimately responsible for remembering your appointment date and time, we will call you one to two business days before your appointment to remind you.**

- **Confirming Appointment- If we are unable to speak with you and must leave a voicemail message for you, we request that you call us as soon as possible to confirm your intent to keep your appointment. If you fail to confirm your appointment, it may be given to another patient, so that if you show up for the appointment without having confirmed, we may not be able to accommodate you and you would need to reschedule or wait to be seen.**

- **Failure to Keep an Appointment-If you fail to keep an appointment which has been made for you, it will be considered a missed appointment.**

- **Cancelling Appointments-If you cannot keep your scheduled appointment, you must contact us at least 24 hours in advance to let us know so that we can offer your appointment to another patient. Failure to provide at least 24 hours' notice of cancellation counts as a missed appointment.**

- **Late Appointments-If you show up more than 10 minutes late for your appointment, it may be considered a missed appointment Your appointment may have been given to a waiting patient, in which case you may be required to reschedule, or have to wait to be seen.**

- **Consequences of Missed Appointments- If within the same 12-month interval you have three (3) missed appointments, either failing to keep an appointment, cancelling with less than 24 hours' notice, showing up more than 10 minutes late, or any combination thereof, your attending practitioner will be notified. That practitioner, in consultation with the Medical or Dental Director, will make a decision regarding whether or not you will be dismissed as a patient. If the decision is made to dismiss you as a patient, you will receive notification by Registered Mail that you have been permanently dismissed as a patient from all ACCESS Family Care Medical and Dental Clinics.**

Please speak to any of the clinic staff if you have questions about this No-Show Patient Policy Agreement.

I have read, understand and agree to abide by this No-Show Patient Policy Agreement.

_____ _____

Patient Name (PLEASE PRINT NAME) Date

_____ _____

Parent/Guardian (for patients under 18)/Patient Signature Date

HEALTH INFORMATION EXCHANGE
PATIENT INFORMATION

ACCESS Family Care participates in a health information exchange so that your care providers can access your electronic health records from other health care providers. This form provides information on Midwest Health Connection and how AFC shares your records with the health information network so your care provider can share and access your electronic health records so that your care team can make the best care decisions for you. Your health records exist in many places. MHC connects your providers, hospitals and labs to each other. With a more complete picture of your health, your health care team can take better care of you In the doctor's office, hospital or emergency room. You won't have to collect records from different providers or remember lab and medication history, it will be available to your care team 24/7.

Who has access to the MHC Network?
Only health care professionals, health plans, and other authorized recipients will have access to your medical records, to the extent permitted by law, including for treatment, payment, and healthcare operations purposes. Medical record information is protected by federal and state law and records shared with a health information exchange will comply with those laws. You can ask ACCESS Family Care staff for a list of health care providers who have seen your records or accessed them from the health information exchange.

Please read the statements below:

- ACCESS Family Care may participate in one or more health information exchanges (HIEs) and may electronically share your medical information for treatment, payment, health care operations, and other authorized purposes, to the extent permitted by law, with other participants in the HIEs.

- The types of medical information that may be shared through HIEs, includes, but is not limited to: diagnoses, medications, allergies, lab test results, radiology reports, health plan enrollment and eligibility. Such information may also include health information that may be considered particularly sensitive to you, including: mental health information; HIV/AIDs information and test results; genetic information and test results; STD treatment and test results, and family planning information.

- The inclusion of your medical information in an HIE is voluntary and subject to your right to opt-out. If you do not opt-out, we may provide your medical information in accordance with applicable law to the HIEs in which we participate. If you would like to opt-out of the health information exchange, please ask an AFC staff member for an opt-out form.

- If you choose to opt-out of data-sharing through HIEs, your information will no longer be shared through an HIE, including in a medical emergency; however, your opt-out will not modify how your information is otherwise accessed and released to authorized individuals in accordance with the law, including being transmitted through other secure mechanisms (i.e., by fax or an equivalent technology).

- Current law allows my providers who are treating me to copy or include my health data in their own medical records. Even if I later cancel my consent, providers I've visited who have copied my records are not required to remove them.

- The health information exchange will keep track of who views my health records to make sure they are secure.

- AFC has penalties in place for anyone sharing my data in the wrong way and if I suspect or learn that my data was shared or accessed the wrong way, I may contact ACCESS Family Care at 417-451-0619 and ask to speak with the Privacy Officer.

- More information on Midwest Health Connection can be found at https://www.mhc-hie.org/