Broad Top Health & Wellness

BTAMC Inc.

ANNUAL PATIENT REGISTRATION FORM

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As a Federally Qualified Health Center (FQHC), we are required to collect the following information on all the patients we serve. Per federal privacy rules (HIPAA) protected information is kept confidential and is not disclosed, unless authorized by the patient. Thank you for your cooperation and choosing BTAMC as your health care provider.

PLEASE PRINT THE INFORMATION, BELOW.

TODAY'S DATE: _____ **DATE OF BIRTH:** _____ **SEX:** _____M _____F

PATIENT FULL NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **CELL PHONE:** _____ **WORK PHONE:** _____

EMAIL: _____ (please circle) **I DO / I DON'T** authorize BTAMC to leave a detailed message

MARITAL STATUS: _____Single _____Married ____Domestic Partner _____Divorced _____Separated _____Widowed

PRIMARY LANGUAGE: (please circle) ENGLISH SPANISH SIGN LANGUAGE OTHER: _____

ETHNICITY: (please circle) LATINO/HISPANIC NON-LATINO/HISPANIC NOT REPORTED/REFUSED

RACE: CAUCASIAN AFRICAN AMERICAN ASIAN AMERICAN INDIAN/ALASKA NATIVE HAWIIAN/PACIFIC NATIVE

BI-RACIAL or OTHER: _____

FINANCIAL RESPONSIBILITY (Guarantor) & INSURANCE INFORMATION (Please provide insurance cards)

Relationship to Patient: _____Self/Same as Patient _____Spouse/Partner _____Parent OTHER: _____

Guarantor's Name: _____

Guarantor's Address: _____

Guarantor's PHONE: _____ **Guarantor's CELL:** _____ **SEX:** _____M _____F

Patient's Insurance: _____ **Insurance ID#:** _____

Guarantor/Policy Holder: _____ **Insurance Group#:** _____

Guarantor's Date of Birth: _____ **Subscriber's Social Security#:** _____

Pharmacy: _____ **Mail Order Pharmacy:** _____

PLEASE CIRCLE FAMILY SIZE & ESTIMATE ANNUAL HOUSEHOLD INCOME LEVEL

We ask income information because we receive federal funding for assistance programs that benefit patients with lower incomes.

Family Size	From To	From To	From To	From To	From To	Above
1	$0 - $13,590	$13,591 - $16,987	$16,988 - $20,385	$20,386 - $23,782	$23,783 - $27,180	$27,181 +
2	$0 - $18,310	$18,311 - $22,887	$28,888 - $27,465	$27,466 - $33,042	$33,043 - $36,620	$36,621 +
3	$0 - $23,030	$23,031 - $28,787	$28,788 - $34,545	$34,546 - $40,302	$40,303 - $46,060	$46,061 +
4	$0 - $27,750	$27,751 - $34,687	$34,688 - $41,625	$41,626 - $48,562	$48,563 - $55,500	$55,501 +
5	$0 - $32,470	$32,471 - $40,587	$40,588 - $48,705	$48,406 - $56,822	$56,823 - $64,940	$64,941 +
6	$0 - $37,170	$37,171 - $46,487	$46,488 - $55,785	$55,786 - $65,082	$65,083 - $74,380	$74,381 +
7	$0 - $41,910	$41,911 - $52,387	$52,388 - $62,865	$62,866 - $73,342	$73,343 - $83,820	$83,821 +
8	$0 - $46,630	$46,631 - $58,287	$58,288 - $69,945	$69,946 - $81,602	$81,603 - $93,260	$93,261 +

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Thank you for your cooperation and choosing BTAMC as your health care provider. PLEASE CIRCLE YOUR ANSWER

Education Completed: _____ High School/GED _____ Some College/Trade School _____Business School/College Degree

Employment Status: _____Yes/Full-time _____Yes/Part-time _____No _____No/Retired _____ I am a Military Veteran

_____Self Employed _____I am a Migratory Worker with a Residence _____I am a Seasonal Worker without a Residence

Shelter Status: _____Public Housing _____Doubling-up/Transitional _____Shelter _____Street _____Not Homeless

Student Status: _____Full-time _____Part-time **Sex at Birth:** _____M _____F _____Not Reported/Refused

Gender Identity: _____M _____F _____Transgender Female to Male _____Transgender Male to Female _____Other

_____Uncertain/Don't Know _____Not Reported/Refused

Sexual Orientation: _____Heterosexual/Straight _____ Homosexual/Lesbian/Gay _____Bisexual _____Other

_____Uncertain/Don't Know _____Not Reported/Refused

EMERGENCY CONTACTS & CONSENT TO SHARE PERSONAL HEALTH INFORMATION

Relationship to Patient: _____Spouse/Partner _____Parent/Legal Guardian _____Child _____Other

Contact's Name: _____

Contact's PHONE: _____ **Contact's CELL:** _____ **OTHER:** _____

I authorize BTAMC to share my personal health information with the named persons, as designated below.

Name:_____ **PHONE:** _____ **Relationship:** _____

_____Medical _____Billing _____Scheduling _____All

Name:_____ **PHONE:** _____ **Relationship:** _____

_____Medical _____Billing _____Scheduling _____All

Name:_____ **PHONE:** _____ **Relationship:** _____

_____Medical _____Billing _____Scheduling _____All

TREATMENT & PAYMENT AUTHORIZATION

I authorized treatment for myself, or the identified minor patient. I agree to participate in clinical assessment, treatment and testing as a patient of BTAMC. I understand examination and treatment may be from providers such as, physicians, physician's assistants, nurse practitioners, clinical social workers, interns or students under supervision of a doctor, or other, licensed professionals. I authorize BTAMC to release my medical information needed in the continuum of care with other medical providers or facilities.

I understand that I am financially responsible for all service charges for myself or identified minor, whether or not service is covered by insurance. I understand that I may apply for Sliding Fee Discounts or set up payment arrangements with the Billing Department for charges not covered by insurance. I authorize the release of medical information needed to determine insurance benefits.

As a courtesy, BTAMC will submit claims to an insurance company on my behalf. I understand charges not covered by insurance such as, co-pays, deductibles or sliding fees are my responsibility. Any returned checks by my financial institution will incur a $25.00 fee.

PATIENT / GUARDIAN SIGNATURE: _____ **DATE:** _____

STAFF WITNESS: _____ **DATE/ENTRY:** _____

"The mission of Broad Top Area Medical Center, Inc. is to provide access to affordable, high-quality care without discrimination."