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: _____ ☐ **I DO** ☐ **I DON'T** authorize BTAMC to leave a detailed message

MARITAL STATUS: ☐ Single ☐Married ☐ Domestic Partner ☐ Divorced ☐ Separated ☐ Widowed

FINANCIAL RESPONSIBILITY (Please provide insurance cards)

Guarantor Information – List person or insured name responsible for bill **(If different than patient)**

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#:** _____

PREFERRED PHARMACY

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

ON THE TABLE BELOW PLEASE CIRCLE FAMILY SIZE & ESTIMATE ANNUAL HOUSEHOLD INCOME FOR 2023

We ask all patients to share their annual household income range. We collect this information because we receive federal funding for assistance programs that benefit patients with lower incomes. Thank you!

Family Size	(<=100%)	(101% - 125%)	(126% - 150%)	(151% - 175%)	(176% - 200%)	Above 200% FPL
1	$0 - $14,580	$14,581 - $18,225	$18,226 - $21,870	$21,871 - $25,515	$25,516 - $29,160	$29,161 +
2	$0 - $19,720	$19,721 - $24,650	$24,651 - $29,580	$29,581 - $34,510	$34,511 - $39,440	$39,441 +
3	$0 - $24,860	$24,861 - $31,075	$31,076 - $37,290	$37,291 - $43,505	$43,506 - $49,720	$49,721 +
4	$0 - $30,000	$30,001 - $37,500	$37,501 - $45,000	$45,001 - $52,500	$52,501 - $60,000	$60,001 +
5	$0 - $35,140	$35,141 - $43,925	$43,926 - $52,710	$52,711 - $62,495	$62,496 - $70,280	$70,281 +
6	$0 - $40,280	$40,281 - $50,350	$50,351 - $60,420	$60,421 - $70,490	$70,491 - $80,560	$80,561 +
7	$0 - $45,420	$45,421 - $56,775	$56,776 - $68,130	$68,131 - $79,485	$79,486 - $90,840	$90,841 +
8	$0 - $50,560	$50,561 - $63,200	$63,201 - $75,840	$75,841 - $88,480	$88,481 - $101,120	$101,121 +

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The data you provide is for continued grant funding and your personal information is not reported.
You may choose NOT to disclose some information below. Please select "Not Reported/Refused".
Thank you for your cooperation and choosing BTAMC as your health care provider.

Employment Status: ☐ Full-time ☐ Part-time ☐ Self Employed ☐ Military Veteran
☐ Migratory Worker with a Residence ☐ Seasonal Worker without a Residence
☐ Retired ☐ Disabled ☐ Student

Shelter Status: ☐ Houseless-Street ☐ Houseless-Shelter ☐Doubling-up ☐ Public Housing ☐ N/A

Gender Identity: (How do you identify yourself today?)
☐ Male ☐ Transgender Male/Female-to-Male ☐ Refuse/Other: _____
☐ Female ☐ Transgender Female/Male-to-Female ☐ Non-binary

Sexual Orientation: ☐ Straight or Heterosexual ☐ Lesbian, Gay or Homosexual ☐ Not Reported/Refused
☐ Bisexual ☐ Pansexual ☐Asexual ☐ Queer ☐ Uncertain/Don't Know

EMERGENCY & NON-EMERGENCY CONTACTS & CONSENT TO SHARE PERSONAL HEALTH INFORMATION

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

Name: _____ **PHONE:** _____ **Relationship:** _____
☐ **Emergency Contact** ☐ Medical ☐ Billing ☐ Scheduling

Name: _____ **PHONE:** _____ **Relationship:** _____
☐ **Emergency Contact** ☐ Medical ☐ Billing ☐ Scheduling

Name: _____ **PHONE:** _____ **Relationship:** _____
☐ **Emergency Contact** ☐ Medical ☐ Billing ☐ Scheduling

Name: _____ **PHONE:** _____ **Relationship:** _____
☐ **Emergency Contact** ☐ Medical ☐ Billing ☐ Scheduling

TREATMENT & PAYMENT AUTHORIZATION

As a patient of BTAMC, I authorize treatment for myself, or the identified minor. I consent to clinical assessment, treatment, testing or tele-health services, including audio/visual or audio only encounter. I understand BTAMC uses an integrated, team-based approach to evaluation and management. Services may include primary medical care, integrated behavioral health, preventative/additional dental services, patient outreach/support and assistance, care management services, and/or some specialty services. Additionally, our integrated care specialists may provide consultation, behavioral health assessments, counseling interventions or support services, as you and your BTAMC provider decide are appropriate. I authorize BTAMC to release my medical information for the continuum of care with other medical providers and facilities, or with insurance payors to seek reimbursement for services provided.

I understand that I am financially responsible for all service charges for myself or identified minor, whether or not the service(s) are covered by insurance. BTAMC will submit claims to my insurance company to secure payment for all services provided. I understand charges not covered by insurance such as, co-pays, co-insurance, deductibles or sliding fees are my responsibility. I understand that I may apply for Sliding Fee Discounts or set up payment arrangements with the BTAMC Billing Department. I understand any checks returned by my financial institution will incur a $25.00 charge.

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

Data Entry- Staff Initials:_____**Date:** _____ **Scanned – Staff Initials:**_____**Date:** _____

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

Broad Top Area Medical Center, Inc.

2023 SLIDING FEE SCALE DISCOUNT PROGRAM – PATIENT EDUCATION

FEDERAL POVERTY GUIDELINES

Broad Top Area Medical Center Inc., (BTAMC) is a non-profit Federally Qualified Health Center, our Mission is to provide access to affordable, high-quality healthcare without discrimination based on one's race, color, sex, disability, age, creed, or national origin. BTAMC will provide in-scope services to all patients, regardless of their insurance status or ability to pay. Every patient may apply for our Sliding Fee Scale Discount Program (SFS) to determine qualification. Patients may choose to decline the benefit program.

Eligibility for Sliding Fee Discounts is based on the federal poverty level (FPL) income guidelines which are adjusted annually and operate in accordance with other federal program regulations. **All** patients are encouraged to apply. Uninsured and under-insured patients may qualify for the program based on their household size and their family's income. Sliding Fee Scale Discount Program applications are available on-line or at our reception desks.

Important discount program points are:

- The Sliding Fee Scale provides significant discounts for BTAMC's **Medical** and **Dental** services**.**
- The Sliding Fee Scale **is not** an insurance program – it is a benefit offered to ALL patients.
- You may qualify for the program, even if you have medical insurance coverage.
- You must apply for the program to determine eligibility for Sliding Fee Scale Discounts
- You must provide documentation for proof of income to complete the application process.
- Your eligibility is based on the gross income for your household and your household size.
- You are encouraged to re-apply anytime your household income or household size changes, such as when someone becomes unemployed, or you add a family member – even then the change is temporary.
- **You must renew applications and submit proof of income, annually.**
- The Sliding Fee Scale benefit year is from **March 1st to the last day of February**.
- Applications & questions can be submitted to the office in person, by mail or via secure Email to: enrollment@broadtopmedical.com

2023 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

* For families/households with more than 8 persons, add **$5,140** for each additional person.

ON THE TABLE BELOW PLEASE CIRCLE FAMILY SIZE & ESTIMATE ANNUAL HOUSEHOLD INCOME FOR 2023

We ask all patients to share their annual household income. We collect this information because we receive federal funding for assistance programs that benefit patients with lower incomes. Thank you!

Family Size	Slide A (<=100%)	Slide B (101% - 125%)	Slide C (126% - 150%)	Slide D (151% - 175%)	Slide E (176% - 200%)	Above 200% FPL
1	$0 - $14,580	$14,581 - $18,225	$18,226 - $21,870	$21,871 - $25,515	$25,516 - $29,160	$29,161 +
2	$0 - $19,720	$19,721 - $24,650	$24,651 - $29,580	$29,581 - $34,510	$34,511 - $39,440	$39,441 +
3	$0 - $24,860	$24,861 - $31,075	$31,076 - $37,290	$37,291 - $43,505	$43,506 - $49,720	$49,721 +
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7	$0 - $45,420	$45,421 - $56,775	$56,776 - $68,130	$68,131 - $79,485	$79,486 - $90,840	$90,841 +
8	$0 - $50,560	$50,561 - $63,200	$63,201 - $75,840	$75,841 - $88,480	$88,481 - $101,120	$101,121 +

☐ **I understand that I may qualify for the Sliding Fee Discount Program but at this time, I choose to decline.**

☐ **Yes, I would like to apply for the sliding fee discount program, please contact me.**

_____ _____

Print Name Date of Birth Signature Date

_____ _____

Witness Date