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 from every patient 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.

Patient Demographic Information

Last:	First:	Middle:	
Date of Birth:	Legal Sex: ☐ M ☐ F	Preferred Name:	
PO Box/Street & Apt #:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	

Email Address:

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

Marital Status:
☐ Single ☐ Married ☐ Domestic Partner
☐ Divorced ☐ Separated ☐ Widowed

Homebound:
☐ Yes ☐ No

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 ☐ Declined/Refused
☐ Female ☐ Transgender Female/Male-to-Female ☐ Non-binary

Sexual Orientation: ☐ Straight or Heterosexual ☐ Lesbian, Gay or Homosexual ☐ Bisexual
☐ Other: _____ ☐ Declined/Refused ☐ Uncertain/Don't Know

Insurance Coverage **Please provide insurance card(s)**

Primary Insurance Name: Policy #:		Group #	Insurance Phone:
Insurance PO Box/Street Address:	City	State	Zip
Secondary Insurance Name: Policy #		Group #	Insurance Phone:

Responsible Party (*if patient is not financially responsible*)

Last:	First:	Middle:
Date of Birth:	Address:	Phone:
Social Security Number:	City State	Zip

Relationship: ☐ Self/Same as Patient ☐ Spouse/Partner ☐ Parent ☐ Other Please Describe _____

Email Address:

Employment Information

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

Occupation:	Employer Name:	Phone #:	
Po Box/Street Address	City	State	Zip

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Patient Pharmacy Information

Pharmacy Name: Pharmacy Telephone Number:

Address City State Zip

Emergency & Non-Emergency Contacts & Consent to share personal health information

I authorize BTAMC to share my personal health information with the individuals listed 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

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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 services, preventative or 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:** _____

Broad Top Area Medical Center, Inc.

2025 SLIDING FEE SCALE DISCOUNT PROGRAM – PATIENT EDUCATION & INTEREST FORM

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 our 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 at every BTAMC reception desk and on-line – visit our web site: www.broadtopmedical.com

Important discount program points are:

- The Sliding Fee Scale provides significant discounts for **Medical** and **Dental** services at every BTAMC location.
- The Sliding Fee Scale **is not** an insurance program – it is a benefit offered to ALL of our patients.
- The Sliding Fee Scale benefit period is from **March 1st to the last day of February**.
- Your eligibility is based **only** on your household size and the gross annual income for your household.
- You may qualify for the program, even if you do have third-party medical insurance and/or dental coverage.
- You will qualify for the program if your household income is below and/or up to **200 %** of the federal poverty level.
- You must apply for the program to determine your qualified Sliding Fee Scale Discount.
- You must provide proof of income along with your application such as tax forms **or** pay stubs **or** bank statements.
- You are encouraged to re-apply anytime your household income or household size changes, such as when someone loses insurance, someone becomes unemployed, or if you lose **or** add a family member – even when the change is temporary.
- **You must renew your application and submit proof of income each year to qualify for Sliding Fee Scale Discounts.**
- Applications & questions can be submitted to the office in person, by mail or via secure Email to: enrollment@broadtopmedical.com

2025 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA
* For families/households with more than 8 persons, add **$5,500** for each additional person.

ON THE TABLE BELOW PLEASE CIRCLE FAMILY SIZE & ESTIMATED ANNUAL HOUSEHOLD INCOME FOR 2025

We ask every patient to share their annual household income. We only collect aggregate information because BTAMC receives federal funding for assistance programs that benefit patients with lower incomes. Your information is confidential. Thank you!

Family Size	(<=100%)	(101% - 125%)	(126% - 150%)	(151% - 175%)	(176% - 200%)	Above 200% FPL
1	$0 - $15,650	$15,651 - $19,563	$19,654 - $23,475	$23,476 - $27,388	$27,389 - $31,300	$31,301 +
2	$0 - $21,150	$21,151 - $26,438	$26,439 - $31,725	$31,726 - $37,013	$37,014 - $42,300	$42,301 +
3	$0 - $26,650	$26,651 - $33,313	$33,314 - $39,975	$39,976 - $46,638	$46,639 - $53,300	$53,301 +
4	$0 - $32,150	$32,151 - $40,188	$40,189 - $48,225	$48,226 - $56,263	$56,264 - $64,300	$64,301 +
5	$0 - $37,650	$37,651 - $47,063	$47,064 - $56,475	$56,476 - $65,888	$65,889 - $75,300	$75,301 +
6	$0 - $43,150	$43,151 - $53,938	$53,939 - $64,725	$64,726 - $75,513	$75,514 - $86,300	$86,301 +
7	$0 - $48,650	$48,651 - $60,813	$60,814 - $72,975	$72,976 - $85,138	$85,139 - $97,300	$97,301 +
8	$0 - $54,150	$54,151 - $67,688	$67,689 - $81,225	$81,226 - $94,763	$94,764 - $108,300	$108,301 +

☐ **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 at this Phone Number: _____**

_____ _____
Print Name of Patient/Applicant **or** Parent/Guardian Signature of Patient Date

_____ _____
Patient/Applicant's Date of Birth Signature of Staff/Witness Date

rah – CAC/ 1.31.25