

ANNUAL PATIENT REGISTRATION FORM

 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.

(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: _____ SEX: M F

Guarantor's Address: _____

Guarantor's Primary Phone: _____ Employer: _____

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 2024

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 - \$15,060	\$15,061 - \$18,825	\$18,826 - \$22,590	\$22,591 - \$26,355	\$26,356 - \$30,120	\$30,121 +
2	\$0 - \$20,440	\$20,441 - \$25,550	\$25,551 - \$30,660	\$30,661 - \$35,770	\$35,771 - \$40,880	\$40,881 +
3	\$0 - \$25,820	\$25,821 - \$32,275	\$32,276 - \$38,730	\$38,731 - \$45,185	\$45,186 - \$51,640	\$51,641 +
4	\$0 - \$31,200	\$31,201 - \$39,000	\$39,001 - \$46,800	\$46,801 - \$54,600	\$54,601 - \$62,400	\$62,401 +
5	\$0 - \$36,580	\$36,581 - \$45,725	\$45,726 - \$54,870	\$54,871 - \$64,015	\$64,016 - \$73,160	\$73,161 +
6	\$0 - \$41,960	\$41,961 - \$52,450	\$52,451 - \$62,940	\$62,941 - \$73,430	\$73,431 - \$83,920	\$83,921 +
7	\$0 - \$47,340	\$47,341 - \$59,175	\$59,176 - \$71,010	\$71,011 - \$82,845	\$82,846 - \$94,680	\$94,681 +
8	\$0 - \$52,720	\$52,721 - \$65,900	\$65,901 - \$79,080	\$79,081 - \$92,260	\$92,261 - \$105,440	\$105,441 +

As a Federally Qualified Health Center (FQHC), we are required to collect the following information from every patient we serve.

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 "Declined /Refused".

Thank you for your cooperation and choosing BTAMC as your health care provider.

Employment Status: Full-time Part-time **Employer Name:** _____ **Phone #** _____
 Self Employed Military Veteran Retired Disabled Student
 Seasonal Worker without a Residence Migratory Worker with a Residence

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 Bisexual
 Other: _____ Declined/Refused 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:** _____
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 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 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.
2024 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 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 at every BTAMC reception desk and on-line – visit 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 patients.
- The Sliding Fee Scale benefit year is from **March 1st to the last day of February**.
- Your eligibility is based only on your household size and the gross income for your household.
- You may qualify for the program, even if you have third-party 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 and assessment process.
- You will qualify if your household income is below and/or up to **200 %** of the federal poverty level.
- You are encouraged to re-apply anytime your household income or household size changes, such as when someone becomes unemployed, or you add **or** lose a family member – even then the change is temporary.
- **You must renew applications and submit proof of income annually for approved Sliding Fee Scale Discounts.**
- Applications & questions can be submitted to the office in person, by mail or via secure Email to:
enrollment@broadtopmedical.com

2024 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

* For families/households with more than 8 persons, add **\$5,380** for each additional person.

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1	\$0 - \$15,060	\$15,061 - \$18,825	\$18,826 - \$22,590	\$22,591 - \$26,355	\$26,356 - \$30,120	\$30,121 +
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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