Highland Health Providers

PATIENT REGISTRATION FORM

Patient Name:_____ **Date of Birth:**_____ **SSN:**_____

Address:_____ **City/State:**_____ **Zip:**_____

Home Phone:_____ **Cell Phone:**_____

Employer:_____ **Work Phone:**_____

Emergency Contact:_____ **Phone:**_____ **Relationship:**_____

If under 18 years of age, responsible person for bill: _____

Phone: _____

Date of Birth of responsible person for bill: _____

Would you like to enroll in MyChart patient portal ___**YES** ___**NO**

Email:_____

Primary Care Physician:_____

INSURANCE INFORMATION

☐ **PRIMARY**

Insurance Name:_____ **Policy#:**_____ **Effective Date:**_____

Policy Holder Name:_____ **SSN:**_____

Policy Holder DOB:_____ **Relationship to Patient:**_____

Employer:_____ **Work Phone:**_____

☐ **SECONDARY**

Insurance Name:_____ **Policy#:**_____ **Effective Date:**_____

Policy Holder Name:_____ **SSN:**_____

Policy Holder DOB:_____ **Relationship to Patient:**_____

Employer:_____ **Work Phone:**_____

☐ **NO ACTIVE INSURANCE**

COMPLETE NEXT PAGE

Highland Health Providers

Confidential Patient Information for FQHC Sites

MARK ALL THAT APPLY TO THE PATIENT

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Partnered ☐ Separated

Sex at Birth: ☐ Male ☐ Female

T

Language: ☐ English ☐ Spanish ☐ Other ☐ ASL/Hearing Impaired

Situation: ☐ Veteran ☐ Smoker ☐ Other ☐ Homeless ☐ Visually Impaired ☐ Language Barrier ☐ Migrant Farm Worker

Race:

- ☐ American Indian
- ☐ Asian
- ☐ Asian Indian
- ☐ Black / African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian
- ☐ Japanese
- ☐ Korean
- ☐ More than 1 race
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Unreported
- ☐ Vietnamese
- ☐ White / Caucasian

Ethnicity:

- ☐ Non-Hispanic / Latino
- ☐ Hispanic / Latino
- ☐ Unreported

If Hispanic /Latino, mark one that applies:

- ☐ Chicano
- ☐ Cuban
- ☐ Mexican
- ☐ Mexican American
- ☐ Mexicano
- ☐ Puerto Rican
- ☐ Spaniard
- ☐ Unreported

Family Size (number of people in your home)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ __

Annual Household Income

- ☐ less than $14,000
- ☐ $14,000 - $20,000
- ☐ $20,001 - $25,000
- ☐ $25,001 - $30,000
- ☐ $30,001 - $35,000
- ☐ $35,001 - $55,000
- ☐ $55,001 - $85,000
- ☐ $85,001 & over

For Office Use Only – Sliding Fee Discount

- ☐ **100% & below**
- ☐ **101% - 150%**
- ☐ **151% - 200%**
- ☐ **200% & over**

END

Highland Health Providers

PATIENT AUTHORIZATION

For Use/Disclosure of Health Care Information

Patient Name:_____ D.O.B. _____ SSN: _____

Best Contact Phone Number between 9:00 am and 5:00 pm:_____

Please select one of the following choices for your pharmacy:

□ **Highland Health Providers Pharmacy**
Highland Health Rx
1402 N. High St. (Ground level)
Hillsboro, Ohio 45133

OR

□ **Pharmacy Name and Location:**
_____
_____
_____

I request and authorize Highland Health Providers, its providers and designee to release private health information about myself by the following names or to the following individuals:

Detailed Message on Answering Machine/Voicemail at "Best Contact Number" above: ⬭ Yes ⬭ No

1) Name: _____ Phone: _____

2) Name: _____ Phone: _____

3) Name: _____ Phone: _____

This authorization expires on: ⬭ Date_____ ⬭ Unlimited

I understand that information pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State privacy laws.

_____ _____
Signature of Patient/Authorized Representative Date

_____ _____
Print Name Relationship to Patient (parent, legal guardian, etc.)

I understand that I may revoke this authorization in writing. If I do, I understand that Highland Health Providers may have previously released information about the individual named above based on the above authorization. I will not hold Highland Health Providers, its providers or designees accountable for releases made prior to receipt of a written revocation or revocation letter.

To revoke this authorization, please write a letter to: Highland Health Providers
1487 North High Street
Suite 102
Hillsboro, Ohio 45133

Highland Health Providers

Consent for Treatment

I give my consent for treatment to Highland Health Providers (Provider of Service). I understand that I am responsible for my bill. I authorize payment directly to the Provider of Service. I authorize release of information to all my insurance companies for information necessary to collect any payments. I further authorize release of medical information to any and all physicians and/or mid-levels, and employees involved in my care. I permit a copy of this authorization to be used in the place of the original. I authorize the use of "signature on file" to be used on all of my insurance submissions. I understand that I am responsible for notifying the office of any precertification or referrals needed for my insurance. This authorization includes release of information concerning HIV Testing Diagnosis or Treatment of AIDS, AIDS-related conditions, any other reportable communicable diseases, Drug/Alcohol Abuse, Drug-related Conditions, and/or Psychiatric/Psychological diagnosis & treatment. Additionally, I give my consent to receive promotional materials from Highland Health Providers, which will include only my name and address; this consent may be revoked by me at any time, either verbally or in writing, by my giving notification to HHP of my revocation.

Statement to Permit Payment of Medicare Benefits to Provider and Patient

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this of a related Medicare claim. This authorization includes release of information conserving HIV Testing Diagnosis or Treatment of AIDS, AIDS-related conditions, any other reportable communicable diseases, Drug/Alcohol Abuse, Drug-related Conditions; and/or Psychiatric/Psychological diagnosis/Treatment. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered Medicare services to the organization furnishing the services or authorize such physician(s) or organization to submit a claim to Medicare for payment to me. I request that the payment under the Medical Insurance Program be made to Highland Health Providers Corporation.

Telehealth

You may be asked to receive treatment via telehealth. Telehealth is where your healthcare provider visits with you and diagnoses you virtually. The healthcare providers at HHP are still responsible for my care. I understand that I hereby consent to such telehealth care covering all approved diagnostic purposes and treatment by my healthcare provider, their assistants or designees as may be necessary in their judgment. I am aware that the practice of medicine, especially telehealth, is not an exact science and I acknowledge that no guarantees have been made as to the results of treatment or examination in HHP. I understand that I have been given an opportunity to have my questions answered regarding use of telehealth, including any security or privacy concerns I may have and that those questions, if any, have been answered to my satisfaction.

_____

Signature of Patient/Patient Representative Date

Consent for Treatment of a Minor Child (Less than 18 years of age)

I give my consent to Highland Health Providers (Provider of Service) to provide medical care and necessary treatment to

_____, a minor child. I acknowledge that I am an authorized parent or legal guardian and have authority to consent for the medical care of the identified minor child.

_____

Signature of Parent/Legal Guardian Date

_____ _____

Print Parent/Guardian Name Relationship to Patient

_____ _____

Parent/Guardian Phone Number Parent/Guardian Email address