



**ST. FRANCIS FAMILY HEALTH CARE
ST. FRANCIS HARDIN MEDICAL CLINIC
PATIENT REGISTRATION FORM**

PLEASE PRINT ALL INFORMATION

PATIENT INFORMATION	LEGAL NAME:		PREFERRED NAME:		
	DATE OF BIRTH:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		SOCIAL SECURITY #:
	ADDRESS:		CITY/STATE/ZIP CODE:		
	HOME PHONE:	CELL PHONE:	WORK PHONE:		
	EMPLOYER:		OCCUPATION:		
	ADDRESS:		CITY/STATE/ZIP CODE:		
	PERSON RESPONSIBLE FOR THIS ACCOUNT:			RELATIONSHIP TO PATIENT:	
	DATE OF BIRTH:	EMPLOYMENT STATUS:		SOCIAL SECURITY #:	
	ADDRESS:		CITY/STATE/ZIP CODE:		
	HOME PHONE:	CELL PHONE:	WORK PHONE:		
EMPLOYER NAME & ADDRESS					
IN CASE OF EMERGENCY, CONTACT:		RELATIONSHIP TO PATIENT:	HOME PHONE:	WORK PHONE:	

INSURANCE	PRIMARY INSURANCE COMPANY:		ID NUMBER:	GROUP NUMBER:		
	SUBSCRIBER NAME:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH:	COVERAGE START DATE:		
	SUBSCRIBER ADDRESS:		CITY/STATE/ZIP CODE:			
	RELATIONSHIP TO PATIENT:	HOME PHONE:	CELL PHONE:	WORK PHONE:		
	EMPLOYER NAME & ADDRESS					
	SECONDARY INSURANCE COMPANY:		ID NUMBER:	GROUP NUMBER:		
	SUBSCRIBER NAME:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH:	COVERAGE START DATE:		
	SUBSCRIBER ADDRESS:		CITY/STATE/ZIP CODE:			
	RELATIONSHIP TO PATIENT:	HOME PHONE:	CELL PHONE:	WORK PHONE:		
	EMPLOYER NAME & ADDRESS:					

ADDITIONAL INFORMATION	THE FOLLOWING INFORMATION IS REQUIRED FOR OUR ONGOING SUPPORT FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICE, HEALTH RESOURCES AND SERVICES ADMINISTRATION, BUREAU OF PRIMARY HEALTH CARE, NATIONAL HEALTH SERVICE CORPS. YOUR COOPERATION IS GREATLY APPRECIATED AND YOUR ANSWERS ARE STRICTLY CONFIDENTIAL.			
	RACE/ETHNICITY:			
	<input type="checkbox"/> ASIAN	<input type="checkbox"/> BLACK OR AFRICAN AMERICAN	<input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE	<input type="checkbox"/> HISPANIC OR LATINO
	<input type="checkbox"/> WHITE	<input type="checkbox"/> NATIVE HAWAIIAN OR PACIFIC ISLANDER	<input type="checkbox"/> OTHER: _____	
	HOW MANY PEOPLE LIVE IN THE PATIENT'S HOUSEHOLD? _____			
WHAT IS THE ANNUAL INCOME BEFORE ALL TAXES IN THIS HOUSEHOLD?				
<input type="checkbox"/> \$ 9,000 OR BELOW	<input type="checkbox"/> \$15,001 TO 18,100	<input type="checkbox"/> \$24,301 TO 27,300		
<input type="checkbox"/> \$9,001 TO 12,000	<input type="checkbox"/> \$18,101 TO 21,200	<input type="checkbox"/> \$27,301 TO 30,400		
<input type="checkbox"/> \$12,001 TO 15,000	<input type="checkbox"/> \$21,201 TO 24,300	<input type="checkbox"/> \$30,401 OR ABOVE		
WOULD IT HELP IF THERE WAS AN INTERPRETER AVAILABLE FOR YOUR VISITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				



ST. FRANCIS FAMILY HEALTH CARE
ST. FRANCIS HARDIN MEDICAL CLINIC
CONSENT FORM

CONSENT FOR TREATMENT:

I HEREBY AUTHORIZE THIS FACILITY TO RENDER SERVICE, MEDICATION AND TREATMENT AS NECESSARY. IF I SHOULD LEAVE BEFORE COMPLETING MY MEDICAL OR SURGICAL PROCEDURES, EXAMINATION OR TREATMENT, I RELEASE SAID PHYSICIAN OR FAMILY NURSE PRACTITIONER AND THE CLINIC OF ALL RESPONSIBILITY OF ANY AND ALL ADVERSE EFFECTS.

RECORDS RELEASE:

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION CONTAINED IN MY MEDICAL RECORDS TO REFERRING PHYSICIANS, ANY PROVIDER TO WHICH I AM TRANSFERRED, AND INSURANCE COMPANIES IN ORDER TO SECURE PAYMENT OF BENEFITS. I HEREBY RELEASE THE CLINIC FROM ALL LEGAL RESPONSIBILITY OF LIABILITY THAT MAY ARISE FROM THE RELEASE OF SUCH RECORDS. A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

ASSIGNMENT OF BENEFITS:

I HEREBY AUTHORIZE AND ASSIGN PAYMENT TO THIS FACILITY AND/OR INDEPENDENT CONTRACTORS OF ANY TYPE OF REIMBURSEMENT OR PAYMENT DUE FROM MEDICARE OR STATE MEDICAID PROGRAMS OR ANY OTHER INSURANCE PAYOR FOR ANY AND ALL COST INCURRED FOR MY MEDICAL AND RELATED CARE AT THIS FACILITY.

PAYMENT RESPONSIBILITY:

I UNDERSTAND PAYMENT FOR SERVICES IS EXPECTED AT THE TIME OF SERVICE AND THAT I AM RESPONSIBLE FOR PAYMENT OF MEDICAL BENEFITS TO ST. FRANCIS FAMILY HEALTH CARE FOR SERVICES RENDERED TO MYSELF AND/OR DEPENDENTS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.* SHOULD THIS ACCOUNT BECOME DELINQUENT AND BE REFERRED TO A COLLECTION AGENCY OR ATTORNEY, I SHALL PAY ALL REASONABLE COLLECTION EXPENSES, COURT COST, INTEREST AND A REASONABLE ATTORNEY FEE. IF THE ACCOUNT BECOMES DELINQUENT, I AGREE TO ASSIGN TO THE CLINIC ANY RIGHT OR CAUSE OF ACTION I MAY HAVE AGAINST ANY THIRD PERSON TO COLLECT AND RECOVER FOR THE EXPENSE OF THIS ACCOUNT AGAINST ANY THIRD PERSON.

*I FULLY UNDERSTAND AND AGREE THAT MY INSURANCE POLICY IS AN ARRANGEMENT BETWEEN THE INSURANCE CARRIER AND MYSELF. AS A PATIENT, I AM RESPONSIBLE FOR KNOWING THE COVERAGE ARRANGEMENTS OF MY POLICY.

MEDICARE LIFETIME CONSENT:

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE & MEDICARE SECONDARY/MEDI GAP BENEFITS BE MADE ON MY BEHALF TO ST. FRANCIS FAMILY HEALTH CARE FOR ANY SERVICES FURNISHED TO ME BY THE CLINIC. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO CMS CENTERS FOR MEDICARE AND MEDICAID SERVICES (FORMERLY HCFA) AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

ADVANCED DIRECTIVES:

DO YOU HAVE AN ADVANCED DIRECTIVE? Yes No

IF YES, DO WE HAVE A COPY OF YOUR ADVANCED DIRECTIVE ON FILE? Yes No

IF NO, WE NEED A COPY OF YOUR ADVANCED DIRECTIVE FOR YOUR MEDICAL RECORD.

IF YOU DO NOT HAVE AN ADVANCED DIRECTIVE AND WOULD LIKE MORE INFORMATION ON THIS SUBJECT, THERE IS A HANDOUT AVAILABLE.

PATIENT NAME: _____ DATE OF BIRTH: _____

SIGNED: _____ DATE: _____
(PATIENT, SPOUSE, PARENT, GUARDIAN OR RESPONSIBLE PERSON)

RELATIONSHIP, IF OTHER THAN PATIENT _____

WITNESS: _____ DATE: _____