CORNELL SCOTT HILL HEALTH CENTER
Registration Information

PATIENT INFORMATION

Name: _____

Address: _____

_____

City/State: _____

Public Housing: [ ] Yes [ ] No

Phone: _____ [ ] Home [ ] Work [ ] Cell

May we call? [ ] Yes [ ] No Leave message? [ ] Yes [ ] No

Phone: _____ [ ] Home [ ] Work [ ] Cell

May we call? [ ] Yes [ ] No Leave message? [ ] Yes [ ] No

I give CS-HHC permission to contact me at the following e-mail address: _____

Date: _____

Pt. ID # / MRN: _____ Sex: [ ] M [ ] F

Date of Birth: _____

Social Security #: _____

Marital Status: [ ] Married [ ] Domestic Partnership [ ] Single [ ] Divorced [ ] Separated [ ] Widowed

Preferred Language: _____

Translation Required: [ ] Yes [ ] No

EMERGENCY CONTACT – Name, Relationship, Phone

_____

Does this person know you are a patient here? [ ] Yes [ ] No

ADDITIONAL INFORMATION

Race: [ ] White/Caucasian [ ] Black/African American [ ] More than one race [ ] Asian [ ] Other Pacific Islander [ ] Native Hawaiian [ ] American Indian/Alaskan Native

Ethnicity: [ ] Hispanic [ ] Non-Hispanic

Veteran Status: [ ] Veteran [ ] Non-Veteran

US Citizen: [ ] Citizen [ ] Non-Citizen

Homeless: [ ] No [ ] Yes

Employment Status: [ ] Full time [ ] Self Employed [ ] Part time [ ] Retired [ ] Unemployed [ ] Student [ ] Child

FAMILY SIZE/INCOME

Family Size: _____ Annual Income: $ _____

GUARANTOR – Who will be responsible for any self-pay balance?

[ ] Same as Patient

Name: _____

Address: _____

_____

City/State: _____

Patient's relationship to Guarantor : [ ] Self [ ] Child [ ] Spouse

Phone: _____ [ ] Home [ ] Work [ ] Cell

Phone: _____ [ ] Home [ ] Work [ ] Cell

Social Security #: _____

Date of Birth: _____

PRIMARY INSURANCE:

[ ] Same as Patient [ ] Same as Guarantor [ ] Other

Insured Party: _____

Insured Phone: _____ [ ] Home [ ] Work [ ] Cell

Company: _____

Insured ID: _____

Group Number: _____

Patient's relationship to Insured : [ ] Self [ ] Child [ ] Spouse

Social Security #: _____

Date of Birth: _____

SECONDARY INSURANCE:

[ ] Same as Patient [ ] Same as Guarantor [ ] Other

Insured Party: _____

Insured Phone: _____ [ ] Home [ ] Work [ ] Cell

Company: _____

Insured ID: _____

Group Number: _____

Patient's relationship to Insured : [ ] Self [ ] Child [ ] Spouse

Social Security #: _____

Date of Birth: _____

I certify the above information is correct.

Signature: _____ Date: _____

Identity Verified (two required): [ ] Driver's License [ ] State ID [ ] Passport [ ] Insurance Card [ ] Other _____

By: _____ Date: _____ Title: _____

CORNELL SCOTT-HILL HEALTH CENTER

Name:

DOB:

ID/Chart #:

Date:

Consent to Treat / Assignment of Benefits / Acknowledgement of Receipt of Privacy Practices

Initial Each Paragraph after reading

_____ **Consent to Basic Treatment and Diagnostic Procedures**: This is to certify that I, the undersigned, consent to the administration of treatment at the CS-HHC which includes: all of the health center sites and outreach programs listed in our privacy notice, residents and students in training to be physicians, physician assistants, nurses, therapists, allied health personnel or any provider under contract with CS-HHC. I consent to any x-ray, laboratory or other medical/dental procedures or examination and any other service rendered to me under the general and specific instruction of my physician/dentist/ provider. I understand that, except in an emergency, all special procedures, blood or plasma transfusions, use of anesthetics or conscious sedation, will be discussed with me by my physician/dentist and that an additional informed consent may be required.

_____ **Assignment of Benefits**: I certify that the information given by me in applying for payment by Medicare or Medicaid of the Social Security Act, general assistance or commercial insurance carrier is correct. I authorize any holder of medical or other information about me to release to these third party payors any information needed for claims. I request the payment of authorized benefits be made on my behalf. I assign the benefits payable for hospital/clinic (or physicians) services to the hospital/clinic (or physicians) furnishing the services, and authorize such hospital/clinic (or physicians) to submit claims to potential third-party payors for me.

_____ **Consent to Release Medical Information**: I consent to allow the CS-HHC, as defined above, to use and disclose my protected health information to carry out my treatment, to obtain payment, and to carry out health care operations. My protected health information may include medical/dental/behavioral health information or any information pertaining to the examination, treatment, history, which may include Psychiatric, HIV/AIDS, sickle cell, alcohol and/or drug abuse information, coded medical/dental/ behavioral health information and charges to my health plan and/or their acting intermediaries and/or agents. My protected health information may be disclosed to my health plan and/or its agents as necessary to verify benefits, authorize services, and process claims. My protected health information may be disclosed to other health agencies or institutions involved in my continuing care. This consent is subject to revocation at any time except to the extent that action has been taken in reliance on it; withdrawal of consent shall be addressed in writing to the Privacy Officer.

_____ **Registration/Guarantee of Payment**: Registration as a patient, on behalf of a minor patient, or on behalf of an incapacitated adult presumes that you have proven your identity and/or relationship to the patient in a legally appropriate manner. It is against the law to misrepresent yourself as the patient, or to misrepresent your legal status with respect to making medical decisions on behalf of yourself or a patient. It is your responsibility to provide adequate tangible proof of identity at the time of registration and admission. I authorize my health plan to pay benefits directly to CS-HHC, or any provider under contract with them. I understand that in the event my health plan or health care contract does not cover services, I will be responsible for payment. Examples include co-payments, deductibles, charges considered to be beyond usual, customary and reasonable, or uncovered services.

_____ **SELF-PAY:** I understand that if my health plan does not consider CS-HHC or any other provider under contract with them, a participating provider, charges incurred will be paid by me. I further agree to accept full financial responsibility for payment of charges. In addition, if claims for damages arise as a result of the injuries for which I am being treated, I authorize my attorney/agent to pay all unpaid medical bills owed to CS-HHC related to the injuries out of any proceeds that I receive from any third party. Payment of such medical bills shall be paid before any monies are paid to me personally. I also agree to maintain my account current until settlement is reached. The undersigned agrees that in the event of default in payment, reasonable attorney's fees, allowable interest and reasonable costs of collection may also be added to the amount due on my account."

_____ **Acknowledgement of Receipt: Notice of Privacy Practices**: I understand that specific information regarding the uses and disclosures of my medical information can be found in the CS-HHC Notice of Privacy Practices which has been provided to me, and which I have a right to review before I sign this. I further understand that the CS-HHC has a right to change its Notice of Privacy Practices, and that I may obtain a revised copy on the CS-HHC website, www.hillhealthcenter.com or from Patient Registration areas. I understand that I have the right to request that CS-HHC restrict how my protected health information is used and disclosed for treatment, payment and health care operations. I further understand that CS-HHC is not required to agree to my requested restrictions. However, if CS-HHC agrees to a requested restriction, it is obligated by it.

_____ THIS FORM HAS BEEN EXPLAINED TO ME, AND I UNDERSTAND ITS CONTENTS.

_____ _____ _____

Signature of Patient or Legal Representative *Date* *Relationship to Patient*

Two forms of Identity: □ Drivers License □ State ID □ Passport □ Insurance card □ Other _____

_____ _____ _____

Verified by: Name *Date* *Title*

Although good faith efforts have been made, patient has □ refused to sign □ is unable to sign (e.g., incapacitated)

Explain: □ Emergency Treatment □ Other _____