FAMILY HEALTH CENTERS, INC.

Registration / Registracion

Patient #: ______________________ Guarantor #: ______________________ Today's Date: ______________

☐ Denmark ☐ Norfield ☐ St. George ☐ St. Matthew ☐ Orangeburg ☐ Vance ☐ Holly Hill

GENERAL INFORMATION (Informacion General)

Patient's Name (Nombe del Paciente) ____

Social Sec # (Numero Seguro Social):________-__________-_________ Sex (Sexo): ☐ Female (Fem.) or ☐ Male (Masc.)

Date of Birth (Fecha de Nacimiento): ______________________ Marital Status (Estado Civil): ______________________

Race (Razo): ☐ Black (Negro) ☐ White (Blanco) ☐ Hispanic (Hispano) ☐ Other or Ethnicity: ________ (Otro o Etnicidad) Language: (Idioma Preferido) ☐ English ☐ Spanish

Address (Direccion): ____

City (Ciudad): ______________________ State (Estado): ____________ Zip (Postal): ____________

Cell (Tel. Celular) (   )______________________ Home (Tel. Casa) (   )______________________

Employer (Empleador) ______________________ ☐ None Work (Tel, Trabajo) ______________________

Email Address (Correo Electronico): ______________________________________ ☐ Home ☐ Work

Would you like to receive text message reminders and information? ☐ Yes (Sí) ☐ No

(Te gustaria recibir recordatorios de mensajes de texto e informacion)? ______________________

If yes, at which telephone number (En caso afirmativo, en que numero de telefono)? ______________________

METHOD OF PAYMENT (Metodo de Pago)

PRIMARY INSURANCE (Primario Seguro Nombre de Compania)______________________________________

Policy Number (Numero de la Norma)______________________________ Group #______________________

Subscribers Name______________________________ Date of Birth ______________________

SECONDARY INSURANCE (Secundario seguro nombre de compania): ______________________________

Policy Number (Numero de la Norma)______________________________ Group #______________________

Subscribers Name______________________________ Date of Birth ______________________

DENTAL INSURANCE: ______________________________ Policy #______________________

Subscribers Name______________________________ Date of Birth ______________________

VISION INSURANCE: ______________________________ Policy #______________________

Subscribers Name______________________________ Date of Birth ______________________

Have you applied for, or received, Medicaid (Ha solicitado o recibido, Medicaid): ☐ Yes (Sí) ☐ No

If yes, when (En case afirmativo, cuando)? ______________________________________

Other Specify (Especificacion): ______________________________________

GUARANTOR INFORMATION (Person different from Patient):

Name______________________________________ Date of Birth ______________________

Address______________________________________ City______________________

State______________________________ Zip Code______________________________

Cell Phone ______________________ Work Phone ______________________ Home ______________________

Patient #: ______________________________ Guarantor #: _________________________________

EMERGENCY INFORMATION (Informacion de Emergencia)

Emergency Contact Name (Persona De Emergencia): ____

Emergency Telephone Number (Numero de Emergencia): ____

Parent/Guardian Cell Phone Number (Numero de Celular de Padre/Gueardian): ____

Person's Relationship to Patient (Persona relacionada con el paciente): ____

Would you like to become a member of the Family Health Centers, Inc. Board of Directors?

☐ Yes ☐ No

FEES (Honorarios)

To be considered eligible for our sliding fee discount, you must complete the Sliding Fee Scale portion of the registration form. If you fail to complete the Sliding Fee Scale portion of the registration form, you will be assigned a full pay code for all your services provided by Family Health Centers, Inc.

Para ser considerado elegible para nuestro descuento de programa de bejo recursos/ingreso, debe completer la porcion de verificacion de salario en el registro de tarifas escala. Si usted falla en completer esta porcion del registro usted sera asignado el codigo de pago por todo sus servicios proporcionado Family Health Centers, Inc.

GENERAL RELEASE/ASSIGNMENT OF BENEFITS (Liberacion General/Asignacion De Beneficios)

I hereby guarantee payments of all charges incurred for the amount of this patient including transportation and care at any hospital or other facility by a physician/healthcare provider and assign any benefits for that patient to the Family Health Centers, Inc. I hereby authorize Family Health Centers, Inc. to furnish from its records any information requested by insurance of liable parties in connection with the above assignments.

Quedo por garantizo pagos de todo los cargos contraidos por la sma de este paciente incluyendo tranportacion y cuidado en cualquier hospital o en otra facilidad por un medico y asigno cualquira informacion pedida por seguros de partidos responsables in conexion con las asignaciones de arriba. You autorizo Family Health Center, Inc. para proveer de sus registros toda la informacion solicitada por el seguro de los sujetos pasivos en relacion con las asignaciones anteriores.

Signature (Firma): ______________________ Date (Fecha): ______________

MEDICARE RELEASE/ASSIGNMENT OF BENEFITS (Liberacion de Medicare/Asignacion de Beneficios)

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers, or any additional third party responsible for payment of benefits, any information needed for this or any Medicare claim. I request that payment of the authorized benefits be made on my behalf. I assign payment for the unpaid charges for outpatient and inpatient visits by physicians/healthcare provider for whom Family Health Centers, Inc. is authorized to bill. I understand that I am responsible for any health insurance deductibles and co-insurance.

You certifico que la informacion dada pro mi en aplicar para pago debajo del TITULO ZVIII del Acto del Serguro Social es correcto. Autorizo el portador de cualquiera infrmacion (medica) sobre mi para liberar a la Adminstracion del Seguro Social sus intermiarios o portadores de tercer partido responsible para pago de beneficios, cualquiera informacion necesitado para esta o cualquier reclamo. Pido que pago de beneficios autorizados sean hecho en mi beneficio. Asigno pago de cargos no pagos de visitas de clinica, hospital por medicos, por lo cual Family Health Centers, Inc en autorizado de cobrar. You entiendo que soy responsable por deducible de seguro de salud o co-seguro.

Signature (Firma): ______________________ Date (Fecha): ______________

Relationship to patient (Relacion al paciente):

☐ Self (YO) ☐ Spouse (Esposo) ☐ Parent/Guardian (Padres/Guardian) ☐ Other (Otro): ______________

CONSENT FOR TREATMENT (Consentimiento para Tratamiento)

I hereby authorize Family Health Centers, Inc. to provide medical, surgical, dental behavioral health, health education and hospital treatment including but not limited to any x-ray examinations and injections as may be ordained as advisable or necessary by the attending professional staff.

You autorizo a Family Health Centers, Inc. para proporcionar servicios medicos quirurgicos, odontologicos, de compartamiento, education sanitaria y tratamiento en el hospital, incluyendo pero sin limitarse a, los examines de rayos X y las inyecciones que pueden ser ordenados como conviente o necesario por el personal de asistencia professional.

Signature (Firma): ______________________ Date (Fetcha): ______________

Relationship to patient (Relacion al paciente):

☐ Self (YO) ☐ Spouse (Esposo) ☐ Parent/Guardian (Padres/Guardian) ☐ Other (Otro): ______________

ADDITIONAL INFORMATION (Informacion Adicional)

Over the past 2 years have you or anyone in your family (Durante los ultimos 2 anos usted o algun miembro de su familia)?
Worked on a farm (trabajo en una finca)? ☐ Yes (Sí) ☐ No

1. Was it – Year Round (Era toda el ano): V or (o) Seasonal Basis (Por bas estacional): ?
2. Received most of your income from Farm Work (Recibido la mayoria de su ingresos de trabajo Agricola): ☐ Yes (Sí) ☐ No
3. Did you move temporarily to do Farm Work (Se mudo temporariament para hacer trabajo Agricola)? ☐ Yes (Sí) ☐ No

Are you a veteran (Es usted un veteran)? ☐ Yes (Sí) ☐ No

Is Family Health Centers, Inc. your Primary Medical Home or do you have another Primary Care Physician/Provider?
(Es Family Health Centers, Inc. Su Casa de Salud Primaria o tiene otro Atencion Primaria Medico/Proveedor)? ☐ Yes (Sí) ☐ No

If no, who (Si no, quien)? ____________________

Is Family Health Center, Inc. your preferred pharmacy (Es Family Health Center, Inc. su farmacia preferida)? ☐ Yes (Sí) ☐ No

If "No", which pharmacy is preferred (Si "No", farmacia que se prefiere)?

Who referred you to Family Health Center, Inc. (Quien lo refirio a Family Health Center, Inc.)? ____________________

ADVANCE DIRECTIVES QUESTIONNAIRE (Las Volumtades Anticipadas Cuestionario)

Have you been provided with information regarding South Carolina State law and Family Health Centers', Inc. policy on Advance Directives (Living Will or Health Care Power of Attorney) (Ha recibido information a respect a la ley del Estado de Carolina del sur Family Health Centers, Inc. politica en las Directivas Anticipadas (Testamento en Vica o Poder de Abogad para Atencion Medica)?
☐ Yes (Sí) ☐ No

Do you have an Advance Directive (Tiene una Directiva Avanzada)? ☐ Yes (Sí) ☐ No
If yes, is it a: Living Will (En caso afirmativo, es una: Testamento en Vica)
Or, Health Care Power of Attorney (Poder Notarial para Atancion Medica)
If yes, bring a copy for your medical records (En caso afirmativo, por favor traiga una copia para sus registros medicos).

If your Advanced Directive is not on file at a hospital, may we forward a copy to the hospital of your choice (Si su directive avanzada no se encuentra archivada en un hospital, podemos enviar una copia all hospital de su eleccion)? ☐ Yes (Sí) ☐ No

If yes, which hospital (en caso afirmativo, en que hospital): ____________________
If you do not have an Advance Directive, would you like assistance in formulating an Advance Directive (Si usted no tiene una directive anticipado, quires ayuda para formular una directive anticipada)? ☐ Yes (Sí) ☐ No

SIGNATURE (Firma)

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge (Declaro bajo pena de perjurio, que he examindo toda la informacion en esta forma, y en cualquier declaracion de acompanamiento de las formas, y es verdadera y correcta a lo major de mi conocimiento).

Patient or Authorized Representative's Signature
(Paciente o Representante Autorizado Firma): ____________________

Print Patient's Name (Escriba el nombre del paciente): ____________________

Relationship to Patient (Relacion con el paciente): ____________________ Date: ____________________

Witness Signature (Firma de Testigo): ____________________Date: ____________________

Protected Health Information / Informacion de Salud Protegida

Patient Name (Nombre del Paciente): ______________________________

Date of Birth (Fecha de Nacimiento): ______________________________

Receipt of Notice of Privacy Practices Obtained

(Recibo del Aviso de Practicas de Privacidad Obtenido)? ☐ Yes (Sí) ☐ No Date (Fecha): ________________

For your protection, please list individuals whom you are granting access to your health information.
(Para su proteccion, a liste las personas a quien se le dan acceso a su informacion de salud.):

Print Name (Nombre)	Relationship (Relacion)	Telephone (Telefono)
______	______	______
______	______	______
______	______	______
______	______	______

Restriction(s) Requested by Patient (Approved by the Organization)
(Restriccion(s) Solicitada por el Paciente (Aprobado por el Organizacion):

For Your Protection, please list any restrictions for communicating your health information.
Para su proteccion, por favor indique cualquier restriccion para communicacion de su informacion de salud.):

____

____

____

Organizational Restriction(s) Approved (Restriccion(s) de Organizacion Aprobo)? ☐ Yes (Sí) ☐ No

I understand that the access granted and restrictions listed above will apply until I officially request a change (Yo entiendo que el acceso concedido y las restricciones mencionadas anteriormente se aplicaran hasta que oficialmente solicitor un cambio.) ☐ Yes (Sí) ☐ No

______________________________ ______________

Patient/Legal Guardian Signature (Paciente/Tutor Legal Firma) Date (Fecho)

______________ ______________ ______________

Witness Print (Firma de Testigo) Signature Date

FAMILY HEALTH CENTERS, INC.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Please Read Carefully

These Privacy Practices apply to Family Health Center, Inc. (FHC) including, without limitation to the following facilities: St. Matthews Family Health Centers; Norfield Medical Center; St. George Medical Center; Denmark Medical Center; St. George Medical Center; Community Medical Center; Family Health Centers at Holly Hill; and FHC at Orangeburg – all of which are referred to as FHC in this notice. These Privacy Practices also apply to healthcare providers while they treat you at FHC.

Understanding Your Health Record/Information

Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment and plans for future care of treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment;
- Means of communication among the many health professionals who contribute to your care;
- Legal documents describing the care you received;
- Means by which you or third party payer can verify that services billed were actually provided;
- Tool in educating health professionals;
- Source of data for medical research;
- Source of information for public health officials charged with improving the health of the nation;
- Source of data for facility planning and marketing;
- Tool with which we can access and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where and why others may access your health information and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is physical property of the healthcare provider or facility that compiled it, the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect and obtain a copy of your health record.

You have the right to request that FHC communicate with you in a certain way. For example, you may ask that FHC on conduct communications about your health information with you privately with no other family members present. If you wish to receive confidential communications, please inform your registration personnel or your nurse. FHC will not request that you provide any reasons for your request and will attempt to honor reasonable requests for confidential information.

You have the right to obtain an accounting of disclosures of your health information and the right to revoke authorization to use or disclose health information, except to the extent that action has already been taken.

If you believe that your health information records are incorrect or incomplete, you may request that FHC amend those records. Your request must be made in FHC's Compliance Officer in writing. The request to amend your health record may be denied if:

- The information you wish to amend is not maintained by FHC.
- The request is not in writing or does not include a reason for amendment.
- Your health information records were not created by FHC.
- The records you are requesting are not part of FHC's record.
- The health information you wish to amend is not part of the health information you or your legal representative is permitted to inspect a copy.
- In the opinion of FHC, the records containing your health information are accurate and complete.

Our Responsibilities

FHC is required to maintain the privacy of your health information, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information we maintain. Should our information practices change, we will provide a copy of the revised notice to you or your representative. We will not use or disclose your health information without your written authorization, except as described in the notice.

Revised March 1, 2017

Notice of Privacy Practices / Aviso de Practicas de Privacidad

I HEREBY ACKNOWLEDGE RECEIPT OF FAMILY HEALTH CENTERS', INC. "NOTICE OF PRIVACY PRACTICES".
(Por la presente acuso recibo de Family Health Centers', Inc. "Aviso de practicas de privacidad".)

Print Name (Nombre): ____

Signature (Firma): ______________________________ Date (Fecha): ______________

Witness Print (Firma de Testigo): ____________________ Sign: ______________ Date: ________

Revised March 1, 2017

FAMILY HEALTH CENTERS, INC.

Patient's Rights and Responsibilities

PURPOSE: To outline the basic rights and responsibilities of Family Health Centers, Inc. patients.

POLICY: It is the policy of Family Health Centers, Inc. to provide services that are sensitive to the basic rights of human beings for independence of expression, decision and action. Family Health Centers, Inc. recognizes that during illness, the concern for personal dignity and human relationships are always of great importance. Family Health Centers, Inc. further recognizes that patients have a right to expect the following when receiving services:

RIGHTS:

Respect and Dignity – The patient will be treated with dignity and respect at all times under all circumstances.

Privacy and Confidentiality – The patient has the right to expect their personal information to be kept confidential as required by law.

Personal Safety – The patient has the right to expect reasonable safety while at Family Health Centers, Inc.

Identity – The patient has the right to know the identity and professional status of individuals providing service and to select their Primary Care Provider.

Information – The patient has the right to obtain, from the practitioner responsible for coordinating their care, complete and current information concerning their diagnosis (if know), treatment plan, any known prognosis and provider generated and monitored referrals, as appropriate.

Assistance – The patient has the right to ask questions and discuss problems that arise during an office visit.

Decision Making – The patient, along with the provider, has the right to make decisions regarding their treatment.

Consultation – The patient, at their own request and expense has the right to consult with a specialist.

Refusal of Treatment – The patient may refuse treatment to the extent permitted by law.

Patient Charge – The patient has the right to request and receive an itemized and detailed explanation of the total bill for services rendered.

RESPONSIBILITIES:

Family Health Centers, Inc. as a provider of health services has a right to expect reasonable, responsible behavior on the part of patients. Such behavior includes:

Patient Rules and Regulations – The patient is expected to follow rules and regulations of conduct at Family Health Centers, Inc.

Provision of Information – The patient has the responsibility to provide, to the best of their knowledge, accurate and complete information about present and past illness, hospitalizations, medications and other matters relating to their health.

Compliance with Instructions – The patient is responsible for following the treatment plan recommended by the provider.

Refusal and Treatment – The patient is responsible for the consequences of their actions if treatment is refused or if the provider's instructions are not followed.

Patient Charges – The patient is responsible for assuring that the financial obligations incurred in providing their health care are fulfilled as promptly as possible.

Respect and Consideration - The patient is responsible for being considerate of the rights of other patients and staff, and for assisting in the control of noise and the cleanliness of the center.

Demographics – The patient is responsible for providing current address, telephone number, e-mail address, and insurance information at each office visit.

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Print Patient Name

______________________________________ Date: ______________________

Patient/Legal Guardian Signature