

**PATIENT FINANCIAL RESPONSIBILITY AND AUTHORIZATION FORM****PATIENT NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

Thank you for choosing Family HealthCare. We are committed to providing you with the highest quality of service and care. We ask that you read and sign this form to acknowledge your understanding of our patient policies.

**Acknowledgement and Authorization:** As the patient or patient's guardian, I

- Understand the Notice of Privacy that describes the policies of Family HealthCare related to the use of care records and how to get access to this information upon request.
- Authorize Family HealthCare providers and staff to provide records acquired during my care to the insurance carrier, third party payers, and other physicians or healthcare entities that participate in my care.
- Understand that Family HealthCare respects patient confidentiality and only releases information in accordance with state and federal law.

**Financial Responsibility:** As the patient or patient's guardian, I

- Accept financial responsibility to pay for treatment and care received from Family HealthCare.
- Authorize assignment of payment directly to Family HealthCare and associated entities for all insurance benefits payable for services rendered.
- Agree to pay copayments at the time of service and amounts for coinsurances, deductibles and non-covered services within 30 days from receipt of my billing statement.
- Agree to participate in a Family HealthCare payment plan if I am not able to pay the billed balance in full.
- Understand that I and others on my Family HealthCare account, may be refused service or my account may be sent to collections if I am not willing to pay for the costs of services received.
- Understand that certain tests and lab services are sent outside of Family HealthCare and I will be billed separately by the outside entity for these services.

**Consent for Treatment:** As the patient or patient's guardian,

- Request and authorize Family HealthCare to accept me and/or my child as a patient to provide the services and care identified in the course of assessment and evaluation.
- Understand that this form will be a part of the records until such time as I may choose to revoke this acknowledgement. If I am not the patient, I represent that I am authorized by law to act on the patient's behalf.

**If I am not the patient, I am authorized by law to act on the patient's behalf.**\_\_\_\_\_  
**Patient/Legal Guardian Signature**\_\_\_\_\_  
**Date**\_\_\_\_\_  
**Legal Guardian Name Printed**\_\_\_\_\_  
**Relationship to Patient**

## Patient Registration Information

### Patient Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Parent Name (if child) \_\_\_\_\_ Parent Name (if child) \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Apt #: \_\_\_\_\_  
 City, State and Zip: \_\_\_\_\_ Home Number: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Cell/ Mobile Number: \_\_\_\_\_  
 Marital Status:  Single  Domestic Partner  Married Gender at birth:  Male  Female  
 Social Security #: \_\_\_\_\_ Primary Language: \_\_\_\_\_ Interpreter needed:  Yes  No  
 # Persons in Family/Household: \_\_\_\_\_ Income Amount: \$ \_\_\_\_\_  Weekly  Monthly  Annually  Decline  
 Do you have insurance?  Yes  No *\*\*We offer a discount program to those who qualify, ask us for more information.*

### Emergency Contact:

Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_  
 Relationship to patient: \_\_\_\_\_

### Guarantor / Person Responsible for Charges (if different then information above)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_ Contact Number: \_\_\_\_\_  
 Address: \_\_\_\_\_ City, State and Zip: \_\_\_\_\_  
 Employer Name: \_\_\_\_\_ Employer Phone Number: \_\_\_\_\_  
**Primary insurance:** **Secondary Insurance:**  
 Insurance Company Name: \_\_\_\_\_ Insurance company name: \_\_\_\_\_  
 Subscriber ID#: \_\_\_\_\_ Subscriber ID#: \_\_\_\_\_  
 Group ID#: \_\_\_\_\_ Group ID#: \_\_\_\_\_

### Additional Information

<b>Race:</b> <input type="checkbox"/> American Indian/ Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black/ African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Choose Not to Disclose	<b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non- Hispanic or Latino <input type="checkbox"/> Choose not to disclose  <b>Veteran Status:</b> <input type="checkbox"/> Yes, Veteran <input type="checkbox"/> Not a Veteran	<b>Education Completed:</b> <input type="checkbox"/> High School <input type="checkbox"/> College Degree <input type="checkbox"/> Graduate Degree <input type="checkbox"/> None of the above	<b>Farm Work Status:</b> <input type="checkbox"/> Seasonal <input type="checkbox"/> Year round <input type="checkbox"/> Migrant <input type="checkbox"/> None of the above
<b>Are you homeless?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes: Where do you stay?</i> <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Transitional Housing <input type="checkbox"/> Doubling Up <input type="checkbox"/> Street <input type="checkbox"/> Supportive Housing <input type="checkbox"/> Other	<b>Gender Identity:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender male to female <input type="checkbox"/> Transgender female to male <input type="checkbox"/> Other/Neither Male or Female <input type="checkbox"/> Choose not to disclose	<b>Do you identify as:</b> <input type="checkbox"/> Straight <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Something Else <input type="checkbox"/> Do not know <input type="checkbox"/> Choose not to disclose	<b>Preferred Pronoun:</b> <input type="checkbox"/> He, Him, His <input type="checkbox"/> She, Her, Hers <input type="checkbox"/> They, Them, Theirs <input type="checkbox"/> Other: _____ <input type="checkbox"/> Choose not to disclose

**By signing you are verifying all information above is true and correct.**

**Patient/Legal Guardian Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_