FLINT HILLS
COMMUNITY HEALTH CENTER
YOUR HEALTH + MORE

Registration/Consent Form

PATIENT INFORMATION					Account Number:
PATIENT'S Last Name:	**First Name:**		**MI:**	**Date of Birth:**	**Social Security #:**
PARENT/GUARDIAN Name:	**Marital Status:** □ Single □ Married □ Divorced/Separated □ Widowed		**Maiden name(s)/Other names used?** Please list:		
Mailing Address:		**Apt. No.:**	**City:**	**State:**	**ZIP:**
Primary Phone:	**Text to confirm appointments:** □ Yes □No		**Email Address:**		
Employment Status:	**Employer:**		**Work Phone:**	**Are you a Veteran?** □ Yes □ No	
Gender:	**Gender Identity:**		**Sexual Orientation:**		
Race: □ White □ Black/African-American □ More than 1 race □ Asian □ Other Pacific Islander □ American Indian/Alaska Native □ Native Hawaiian			**Ethnicity:** □ Latino/Hispanic □ Other		
Language:	**Marital Status:**	**Family size:** **Adults:**	**Children:**		

Household Income:	□ **Declined**	
□ Under $15,000 □ $35,000 to $49,999 □ $100,000 to $149,999	□ $15,000 to $24,999 □ $50,000 to $74,999 □$150,000 to $199,999	□ $25,000 to $34,999 □ $75,000 to $99,999 □ $200,000 or Over
During the past two years, have you or a member of your family traveled for employment or been a migrant worker? □Yes □No	**Is Flint Hills Community Health Center your medical home?** □Yes □ No, my primary care provider is (please list):	

EMERGENCY & PRIVACY INFORMATION		
EMERGENCY CONTACT (other than Parent/Legal Guardian):		**Phone Number:**
IF THE PATIENT IS A MINOR, LIST ANYONE 18 AND OVER, OTHER THAN A PARENT/GUARDIAN WHO WILL BRING THE PATIENT TO APPOINTMENTS.		
Name:	**Relationship to Patient:**	**Phone:**
1.		
2.		
3.		

PERSON(S) WHO MAY OBTAIN PATIENT'S PROTECTED HEALTH INFORMATION (including verbal information and/or written records):

Name:	**Relationship to Patient:**	**Phone:**	**Access to Information:**
1.			□ Medical □ Dental □ Behavioral □ Financial
2.			□ Medical □ Dental □ Behavioral □ Financial
3.			□ Medical □ Dental □ Behavioral □ Financial

CONSENT / FINANCIAL AGREEMENT

I give consent for FHCHC to obtain health history, perform laboratory services, perform a physical examination, provide vaccination services and provide treatment as indicated. I give consent to FHCHC to submit claims and receive payment from my insurance carrier on my behalf. I hereby authorize payment of my health insurance benefits to FHCHC. I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductible are designated by my insurance company or health plan I agree to pay them to FHCHC. I authorize FHCHC to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original. I agree that in return for the services provided to the patient by FHCHC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to FHCHC for payment. However, it is understood that the undersigned and/or patient are primarily responsible for the payment of my bill. **I understand this consent will be valid for one year from the signed date.**

Initial Here:

NON-COVERED SERVICES / OUTSIDE LAB & X-RAY PROTOCOL
I understand that FHCHC contracts with health care service plans (i.e. HMO's, PPO's) related only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services included, but are limited to, services not specified as being covered in the patients contracts with health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with FHCHC to obtain necessary health care service plan authorizations. If you have private insurance you are liable for all lab and/or x-rays and the bill will be your responsibility. All outside lab and x-ray charges will be posted to your account at a later date.
Initial Here:

NOTICE OF PRIVACY PRACTICES
Please mark one:
□ I would like a copy of the Notice of Privacy Practices. □ I decline a copy of the Notice of Privacy Practices.

SIGNATURE	
Signature of Patient/Responsible Party:	**Date:**
Relationship to Patient:	**Guardian (if different):**