PLEASE COMPLETE BOTH SIDES OF THIS FORM Rev 8/14/17: 12/11/2018

# ISLAND HEALTH CARE PATIENT REGISTRATION FORM

Name: _____
First Middle Last

SSN __ __ __ - __ __ - __ __ __ __ Date of Birth __/ __/ __ Age ___ □ Female □ Male □ Transgender: M to F □ F to M □

Marital Status: □ Single □ Married □ Significant Other □ Divorced □ Separated □ Widowed

Sexual Orientation: □ Lesbian or Gay □ Straight □ Bisexual □ Something else □ Don't know □ Don't wish to disclose

Employment: □ Full Time □ Part Time □ Not Employed □ Self Employed □ Retired □ Military Duty

Student: □ Full Time □ Part Time □ Not a Student

_____ _____
Mailing Address (PO Box if you have one) Street Address (if different from mailing address)

_____ _____ _____ _____ _____ _____
City/Town State Zip City/Town State Zip

Phone: _____-_____-_____ □ cell □ home □ work Email: _____

**EMERGENCY CONTACT** _____ Phone: _____-_____-_____
Relationship to you: _____

Primary Care Provider: _____ City/State: _____

Primary Insurer: _____ **Provide card to front desk staff**
Subscriber name: _____
Secondary Insurer:_____ **Provide card to front desk staff**
Subscriber Name: _____

**Financial Agreement:** I understand that I am financially responsible for all charges for services provided to me, including the balance remaining after payment of possible insurance benefits according to the terms of my insurer's contract with Island Health Care.

**Assignment of Benefits:** I request that payment of authorized medical benefits be made on my behalf directly to Island Health Care for services rendered. I authorize any holder of medical information about me to release to the state and/or federal administration(s) and its agents or other insurer, any information needed to determine these benefits payable for related services. This Assignment will remain in effect until revoked by me in writing. A photocopy of this Agreement is to be considered as valid as the original.

Signature _____ Date _____/_____/_____

**The following information is required by our funding sources. We will maintain this information in a strictly confidential manner. We appreciate your help.**

| | |
|---|---|
| **1.** Do you live in public housing? Yes__ No__<br>**2.** Are you a military veteran? Yes__ No__<br>**3.** My (family) annual income is: $_____<br>Total number of family members (single = 1): ___<br>Do not wish to report ___<br>**4.** Primary Language Spoken:_____<br>**5.** Are you homeless? (based on where you will sleep tonight) Yes____ No ___<br>**6.** Are you a migrant or seasonal worker? Yes____ No ___ | **7.** Race:<br>White__ Black/African American____<br>Alaska Native/American Indian_____<br>Asian _____ Native Hawaiian_____<br>Other Pacific Islander_____<br>Other (please describe): _____<br>Do not wish to report ___<br>**8.** Ethnicity:<br>Hispanic/Latino ___Non-Hispanic/Latino___<br>Do not wish to report____ |

# AUTHORIZATION FOR TREATMENT & HEALTH SERVICES

NAME_____ DOB _____

Island Health Care Community Health Center (IHC) strives to be a comprehensive health center, responding to community health needs, supporting long-term health and well-being, and empowering individuals to manage their own health and health care. We are committed to providing high quality, accessible and affordable services to all of the patients we serve. IHC providers and staff will work with you to guide and make recommendations regarding your care and treatment.

IHC provides primary care and some behavioral health services. Additional evaluation, such as laboratory, x-ray, other diagnostic studies, specialty referral and treatment, and/or more extensive studies and professional care will be the responsibility of the patient. IHC staff will help to provide assistance in arranging such services.

I understand that in order to provide services, it may be necessary for IHC to communicate with and/or refer to outside resources. I authorize IHC to share my medical information with any health care facility or medical provider as deemed necessary.

Massachusetts law (M.G.L. c. 111, Section 24M) requires providers to report immunization information to a computerized immunization registry known as the Massachusetts Immunization Information System (MIIS). The MIIS stores immunization records for you and your healthcare provider and can help prevent outbreaks of disease like measles and the flu. All information in the MIIS is kept secure and confidential. The MIIS allows information to be shared with health care providers, school nurses, local boards of health, and state agencies concerned with immunization. You have the right to object to the sharing of your immunization information across providers in the MIIS. For more information, please ask your healthcare provider, visit the MIIS website at www.mass.gov/dph/miis or contact the Massachusetts Immunization Program MIIS Help Desk directly at 617-983-4335

I hereby authorize medical treatment by Island Health Care. I understand that medical treatment and procedures are provided by independent practicing physicians or nurse practitioners.

I agree to:

a) give Island Health Care accurate information regarding other providers and facilities who/which are providing health care services to me.

b) participate in the decisions regarding my care and follow recommendations of Island Health Care providers that we mutually agree upon.

c) inform Island Health Care regarding any changes in health and/or reactions to treatment and medications, including pain.

d) provide Island Health Care with insurance or financial information as requested, and to notify Island Health Care of any changes in my insurance and financial circumstances. I understand that my not doing so may create a situation in which I am responsible for payment of services and charges associated with my care.

e) treat Island Health Care personnel with respect.

I understand that it may take 48 to 72 hours to receive certain test results and renewal of prescriptions.

I am aware that some prescription renewals may require that I be seen to reevaluate my treatment plan.

I understand that I am responsible for all of my personal effects during a health center visit.

I retain the right to seek treatment elsewhere at my own expense.

The services of Island Health Care and its professional staff are available during posted health center hours. After-hours answering, nurse triage and provider on-call services may be accessed by calling 508-939-9358. Please refer to the After-Hours Policy posted at the entrance of the health center.

I agree to notify Island Health Care 24 hours in advance if I am unable to keep my appointment.

I understand that if I have any questions or concerns about this form or any health center services or policies, I may arrange to meet with a staff member during health center hours.

I understand that if my insurance provider requires a referral and I do not provide one at the time of my visit to Island Health Care, I may be responsible for the bill.

Patient Signature_____ Date ____/ ____/ ____