Patient Registration Form

Today's Date___/____/_____

Midwest Refuah Health Center

How did you hear about MRHC? ☐ **Family/Friend** ☐ **Social Media** ☐ **Internet Search**

☐ **Newspaper or Magazine Advertisement** ☐ **Online advertisement** ☐ **Medical Provider/Hospital** **Other:** _____

Patient Information (Please present your Photo Identification and Insurance Card with paperwork)

Legal Name: First	Middle	Last	Suffix (Jr, Sr, II, III, etc.)
Preferred Name:		Birth Date: Mon Day Year ____/____/_____	
Street Address Apt/STE/Unit		City State	Zip Code
Cell Phone #		Home Phone #:	
Email Address		Social Security # - -	
Best way to contact me/leave messages ☐Phone/Voicemail ☐Email ☐ US mail			
Emergency Contact Name	Phone	Relation to Patient	
Employer	Primary Care Provider ☐ MRHC ☐ Other_____		
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Unknown			
Sex: ☐ Male ☐ Female ☐ Choose not to disclose	Preferred Pharmacy:		
Preferred Language:	Need an Interpreter? ☐ Yes ☐No		

Insurance Information

Do you have Insurance? ☐ Yes ☐ No	Are you the person responsible for all Bills and Insurance? ☐ Yes ☐ No		
If not, please list legal name and Date of Birth of responsible person: Mon Day Year			
Name:	Date of Birth: / /		
Street Address (if different from above)	City	State	Zip Code
Email Address	Home Phone ( )	Cell Phone ( )	
Primary Insurance Company	Subscriber's Name	ID#	Group #
Secondary Insurance Company	Subscriber's Name	ID#	Group#

Income Midwest Refuah Health Center serves all patients regardless of their ability to pay.

Household Annual income: $_____	Would you like to apply for Financial Assistance with MRHC? ☐ Yes ☐ No ☐ I want to speak to a PSR
Number of adults in household (including you): _____	Number of children in household (under 18 years old): _____

Demographics

Please help us serve you better by selecting the best answers to these questions. Thank you.

What is your Race? *Select up to two*	**Are you Hispanic/Latino?**
☐ White ☐ American Indian/Alaska Native	☐ Not Hispanic/Latino
☐ Black or African American ☐ Asian Indian ☐ Korean	☐ Yes, Mexican, Mexican American, Chicano
☐ Chinese ☐ Vietnamese ☐ Filipino ☐ Other Asian	☐ Yes, Puerto Rican
☐ Japanese ☐ Native Hawaiian ☐ Guamanian or Chamorro	☐ Yes, Cuban
☐ Samoan ☐ Other Pacific Islander ☐ Choose not to disclose	☐ Yes, Another Hispanic, Latino/a, or Spanish Origin
	☐ Choose not to disclose

Housing Status: ☐ Permanent Housing ☐ Public Housing ☐ Homeless

If Homeless : ☐ Street ☐ Homeless Shelter ☐ Transitional ☐ Doubling Up (not paying rent) ☐ Other ☐ Decline to answer

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General Informed Consent for Treatment

I agree to receive routine treatments and procedures that my medical and/or behavioral health provider at Midwest Refuah Health Center (MRHC) decide will help improve my health. This may include routine examinations and treatment, diagnostic and laboratory procedures and tests and medication administration. I understand that my care team will work with me to diagnose and treat my health issues. This consent includes authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis and treatment. Any photographs or other images taken will become part of my health record. MRHC will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require specific informed consent and MRHC will provide me with information and forms prior to such procedures.

Telehealth Consent

By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care. I may withdraw my permission at any time and may elect to not answer questions that may be overheard by another person. I understand that if I do not choose to participate in telehealth, no action will be taken against me. I also understand that technology has limitations, and that telehealth may not eliminate seeing a specialist in person.

Financial Statement/Agreement

I authorize Midwest Refuah Health Center (MRHC) to submit claims to my insurance carrier and to release any medical information necessary to process all claims. I also authorize payment for any medical benefits to MRHC for all services provided until further notified for this account. I agree that I am financially responsible for any co-pay and self-pay balance at the time of service. I agree to pay any deductible and/or any balance that may be due after the claims have been submitted to my insurance. If I cannot make a payment, I can request a payment plan. If I meet criteria such as uninsured, underinsured, or patients with financial barriers, I can access MRHC's sliding scale program at any time. I can also request assistance to transition to state insurance programs.

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

I have been offered a copy of MRHC's Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information (PHI). I understand that MRHC has the right to change its Notice of Privacy Practices from time to time and that whenever an important change is made, MRHC will post a new notice in the office. I may contact MRHC at any time to obtain a current copy of the Notice of Privacy Practices. I may also access a copy on the MRHC website.

Release of Information

I authorize MRHC to use and disclose my health information for the following purposes: To provide for, arrange or coordinate my health care treatment; To enable MRHC to obtain payment for the services it provides to me; To permit MRHC to carry out ordinary health care and business operations such as quality improvement/assurance, service planning and general administration. I am aware that this authorization to use and disclose information may include information regarding HIV or AIDS, Alcohol or drug abuse, Mental illness or any mental health condition, sexually transmitted diseases, family planning, pregnancy and abortion, genetic tests or genetic disease. I am aware that MRHC may share information with my other medical providers for medical treatment or a third party for financial payment through electronic means.

For Text, Voicemail/Answering Machine, or Email Delivery of Information (To Patient Only):

I understand that text, voicemail, or email delivery may not be secure, and that Midwest Refuah Health Center cannot guarantee the privacy or security of my phone number, email address, or related device(s). I understand this risk and consent to and authorize the delivery of the information requested above to me.

_____ _____

Signature of Patient (Parent/Guardian if Minor) Date