Patient Registration Form

Patient Information

Name:

_____

(Last) (First) (Middle) (Preferred to be called)

Address: _____

_____

(City) (State) (Zip Code)

Primary Phone: _____ **Alternate Phone**: _____

Cell ☐ Home ☐ Work ☐ Cell ☐ Home ☐ Work ☐

Email:_____

Would you like to use this as communication with your provider and to receive test/lab results via Patient Portal? Yes ☐ No ☐

How would you like us to contact you? Phone: ☐ Text: ☐ Email: ☐
For text, standard text messaging rates may apply.

What is the best address to send medical information if necessary:

_____

(Address) (City) (State) (Zip)

Date of Birth: ___/___/___ **Social Security Number**:_____--_____--_____

Marital Status:
Divorced ☐ Legally Separated ☐ Married ☐
Single ☐ Widowed ☐

Student Status: Part Time ☐ Full Time ☐

Employment Status:
Part Time ☐ Full Time ☐ Unemployed ☐
Retired ☐ Self Employed ☐ Active Military ☐

What Sex were you at Birth?
Female ☐ Male ☐

We understand the questions below are new. This information helps provide you with the best quality care. There is an option not to disclose to each of the questions. AxessPointe does not discriminate based on this information.

Do you think of yourself as:
Bisexual ☐ Lesbian/Gay ☐ Straight ☐
Something Else ☐ Don't Know ☐
Choose not to disclose ☐

What is your Current Gender Identity?
Female ☐ Male ☐ Transgender ☐
Other ☐ Choose not to disclose ☐

AccessPointe Community Health Centers

Patient Registration Form (cont.)

Employer Name & Address: _____

_____

(City) (State) (Zip) (Phone)

Preferred Pharmacy: _____

(Pharmacy Name) (City) (Phone)

Emergency Contact: _____

(Last) (First) (Relationship)

_____

(Address) (City) (State) (Zip) (Phone Number)

Do you authorize the Emergency Contact to receive medical/dental information of patient?

Yes☐ No☐ If any other person(s) authorized, please list:

_____

(Last) (First) (Relationship) (Phone)

_____

(Last) (First) (Relationship) (Phone)

The following person has permission to bring patient (if patient is minor or disabled) to clinic visits:

_____

(Name of Person(s)) (Phone)

Insurance Information

Name of Responsible Party

_____

(Last) (First) (Middle Initial) (Relation to Patient)

Name of Insured:

_____

(Last) (First) (Middle Initial)

Birth Date of Responsible Party: ___/___/___ Social Security # of Responsible Party: _____--___--_____

Insurance Company Name: _____

Group #/Member ID: _____

AccessPointe Community Health Centers

Patient Registration Form (cont.)

Advanced Directives

Do You Have a: Living Will? Yes ☐ No ☐ DNR? Yes ☐ No ☐

Durable Power of Attorney for Health Care? Yes ☐ No ☐
If so, Whom: _____

Demographic Information

Race: African-American ☐ American Indian/Alaska Native ☐ Asian ☐

Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ More than One ☐ Choose not to disclose ☐

Ethnicity:

Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Choose not to disclose ☐

Preferred Language for Medical Communication: _____

Interpreter Needed: Yes ☐ No ☐

Are you a: Veteran ☐ Migrant Worker ☐ Refugee ☐

Annual Household Income: $0-$11,879 ☐ $15,800-$19,719 ☐ $23,760 or more ☐

$11,880-$15,799 ☐ $19,720-$23,759 ☐ Choose not to disclose ☐

Do you currently receive Public Housing Assistance?

Yes☐ No☐

Do you (please check all that apply):

Stay with a series of friends and/or family members on a temporary basis?

Yes☐ No☐

Stay in supportive or transitional housing (ie. Sober living facility, recovery home)?

Yes☐ No☐

Live in a public or private facility that provides temporary shelter (ie shelter, mission, motel)?

Yes☐ No☐

Have been released from an institution (ie. jail or hospital) without stable housing?

Yes☐ No☐

Live on the streets, in a car, park, abandoned building, or any other unstable situation?

Yes☐ No☐

No-Show Policy

In order to ensure all patients have an equal opportunity to make an appointment with their preferred provider, AxessPointe Community Health Center implements a "No-Show Policy". The following is description of the policy; please sign with agreement at the bottom of page.

Thank you.
AxessPointe Management.

Definition of a "No-Show" Appointment

AxessPointe defines a "no-show" appointment as any scheduled appointment in which the patient does not arrive to the appointment and has not called to cancel or reschedule.

Consequences of No-Show Appointments

If you have three or more no-show appointments in a twelve (12) month period, you will be seen on a same day or walk in basis for three (3) months from the date of the third missed appointment, rather than being able to schedule appointments ahead of time. This may not be with your regular provider. A same day appointment may be available if you call first thing that same morning. As a walk in, we will do our best to fit you in, yet it is not guaranteed that you will be seen the same day. It is possible that you will be waiting only to be asked to try again the next day.

You will receive a phone call after your first and second no-shows to see if you would like to make a new appointment and remind you of this policy. On your third no-show, you will receive a letter in the mail or an email through the patient portal. This letter will note that you have been placed on same day/walk in status for three (3) months and indicate the date you would be able to begin scheduling appointments again ahead of time.

How to Avoid Getting a "No-Show"

1. Confirm your appointment
2. Call to cancel or reschedule. Our phone number is (888) 975-9188.

If you are late to an appointment, you are welcome to wait and see if we can work you in between patients, or you can reschedule for another day.

Always arrive 15 minutes early so that there is time for you and our staff to address any insurance or billing questions, and complete necessary paperwork.

Thank you for trusting us with your well-being.

Patient or Primary Care-Giver Signature Date

CONSENT FOR TREATMENT: I request the employees, agent and staff of AxessPointe Community Health Inc. (API) to perform and hereby consent to such medical, dental treatment and behavioral health care and treatment as may be deemed necessary and/or advisable in the judgment of my treating provider(s). I understand that API is a training site for medical, dental and auxiliary students. I hereby authorize and permit such to participate in my care insofar as they are properly supervised at all times by a licensed and credentialed health care practitioner in that field of expertise. I acknowledge that I have a right to ask questions of any provider or nurse regarding the use of students in my care at any time.

(Patient or Legal Guardian Signature) _____

FINANCIAL RESPONSIBILITY: In consideration of medical services to be received by me, I assign, transfer, and agree to have API be directly reimbursed by my insurance company, managed care organization, or health plan, including Title XVIII of Social Security Administration, for all amounts that it is entitled to collect from such payers as reimbursement. I assume responsibility and agree to pay all costs, charges, and expenses due from me for services which are given to me by API. If my medical insurance is not sufficient to satisfy such costs, charges, and expenses in full, I understand that the resulting balance is my personal responsibility. I agree to pay such established rates for all services provided to me by API.

(Patient Initial)_____

RELEASE OF INFORMATION: I authorize the center to release any and all patient medical/dental and billing information to any provider involved in my treatment; to any pharmacy or other health care facility to which I/the patient is discharged or transferred for treatment, billing, quality assurance, collection or defense of litigation or anticipated litigation; and to any insurance company, review organization or other entity, which is directly or indirectly responsible for payment or review of services provided by API. I consent to use and disclosure of my protected health information to carry out treatment, payment or health or dental care operations by API.

(Patient Initial)_____

AUTHORIZATION TO RECEIVE PRE-RECORDED MESSAGES: I give prior express consent for API, its providers or agents, to contact my designated cellular or residential phones using any type of artificial or pre-recorded voice or auto-dialer technologies for any permissible purpose, including appointment reminders. I understand that treatment may not be conditioned on my agreeing to this provision.

(Patient or Legal Guardian Signature) _____

SLIDING FEE SCALE: Qualifying for our sliding fee scale based on your household income and household size may result in lower charges. You are required to report any income and family size changes to us as this may impact the amount you are expected to pay. We will review and update your information annually. Eligibility cannot be determined until we receive all requested information from you. **If it is determined you are not eligible for a sliding fee and you have incurred charges, you will be expected to pay the balance due**. We will assist you by arranging a payment plan if needed. You will be asked to pay a minimum fee for your first visit until the sliding fee eligibility process is complete. The remaining cost of the first and subsequent visits will be based on the outcome of this determination. If you do not pay for services at the time they are rendered, your balance must be paid in full within sixty (60) days, unless other arrangements have been made

(Patient Initial)_____

MEDICARE/MEDICAID SIGNATURE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized Medicare/ Medicaid benefits be made on my/the patient's behalf for any services furnished by or in the center, including provider services. I authorize any holder of medical, dental or other information about me, to release to API for Medicare and Medicaid services, the Ohio Department of Health and their agents, any information needed to determine these benefits or benefits of related services. I assign the benefits payable for provider and other medical/dental services to the provider or organization furnishing the services and authorize the API provider or organization to submit claim to Medicare and/or Medicaid for payment. I understand that I, the patient, am responsible for any deductibles, co-payments and any applicable percentage of remaining charges.

(Patient Initial)_____

CERTIFICATION AND ACKNOWLEDGEMENT: I certify that all foregoing information and all information supplied by me, as part of the registration process is correct.

_____

Patient/Responsible Party Signature Date

I have been provided with AxessPointe's notice of privacy practices. I understand that I may receive a paper copy upon request.

_____

Patient/Responsible Party Signature Date

API Staff/Witness Signature Date

AccessPointe Community Health Centers

Reduced Rate Application

___ I understand that by not submitting financial information, I am declining the application for Reduced Rates and am 100% responsible for any medical, dental and/or lab fees accrued. If desired, I may apply for Reduced Rates at a later date.

_____ _____

Patient Name Print & Signed

_____ _____

API Staff Date

Personal Information

_____ _____ _____

Last Name First Name DOB

_____ _____ _____

Address City/State Zip Code

_____ _____ _____

Social Security Phone Number Alternative Number

Email:_____

List all dependent household members, including Self & Spouse:

Name	SS#	DOB	Relationship

_____ _____

Patient Signature Date

Reduced Rate Application

Proof of Income

You must provide any of the following proof of income that applies to you; if more than 1 apply, ALL FORMS need to be submitted.

( ) Current Tax Return or Last 3-4 paystubs

( ) Ohio Employment Commission or Unemployment statement

( ) Social Security/Disability Award Letter

( ) Copy of lease agreement/statement from housing authority

( ) Alimony and/or child support award

( ) Notarized Letter of Support or 4506-T

( ) Other proof as requested by API_____

The information I have provided concerning the size of my family and my family's gross annual income from all sources is true, accurate, and complete to the best of my knowledge.

I have given this information concerning my financial situation and my means and ability to pay for the purpose of procuring for my own and my families benefit the discount of my accounts with AxessPointe Community Health Center, Inc. (API). I understand that API will rely on such information to determine applicable discount rate for my account.

I understand that knowingly giving false information in this case may result in criminal prosecution under the laws of the State of Ohio.

I agree to report any change in either my income or my family size to API before or at the time of my next contact or any contact by any family members with API. I know that the information I have given will continue to be relied upon until it is changed.

I understand that yearly I must provide new income verification and my discount status will be reviewed on annual basis and adjusted according to my family income and size at the time of each year's review. If API has reason to suspect that the information I have given is untrue, inaccurate, or that I have not properly reported changes, API may initiate a review of my status and I will authorize access to all my financial records. If I refuse an authorization, API will no longer discount my account.

My signature below indicates that all information I have provided is true to the best of my knowledge.

_____ _____

Applicant signature Date

Office Use Only- **Eligibility Information**

Annual Gross Income: _____ Number of Dependents, including applicant:__

Application Approved Start Date: _____ End Date: _____

MEDICAL/BH & DENTAL SLIDING SCALES

( ) **Slide A**: ($15 Flat Fee Medical/BH visit / $35 Flat Fee Dental visit -**Labs are extra**)

( ) **Slide B:** ($25 Flat Fee Medical/BH visit / $50 Flat Fee Dental visit -**Labs are extra**)

( ) **Slide C:** ($50 Flat Fee Medical/BH visit / $80 Flat Fee Dental visit -**Labs are extra**)

( ) **Slide D**: ($75 Flat Fee Medical/BH visit / $115 Flat Fee Dental visit -**Labs are extra**)

( ) Application Denied- RESPONSIBLE FOR 100% OF CHARGES

Staff Signature: _____ Date: _____

AxessPointe Community Health Centers

Medical and Dental Program Sliding-Fee Discount Guidelines
2016 - 2017

(Based on HHS 2016 Federal Poverty Guidelines)

		A*	B	C	D	E
Medical/Behavioral	Pt. Pays	Flat Fee $15	Flat Fee $25	Flat Fee $50	Flat Fee $75	Full Charge
Dental	Pt. Pays	Flat Fee $35	Flat Fee $50	Flat Fee $80	Flat Fee $115	Full Charge
	% of FPL	<100%	101%-133%	134%-166%	167%-200%	>200%
	1	$11,880	$15,800	$19,721	$23,760	$23,761
	2	$16,020	$21,307	$26,593	$32,040	$32,041
	3	$20,160	$26,813	$33,466	$40,320	$40,321
	4	$24,300	$32,319	$40,338	$48,600	$48,601
	5	$28,440	$37,825	$47,210	$56,880	$56,881
	6	$32,580	$43,331	$54,083	$65,160	$65,161
	7	$36,730	$48,851	$60,972	$73,460	$73,461
	8**	$40,890	$54,384	$67,877	$81,780	$81,781

*For eligible Slide A patients seen at Broadway WH - the $15 Medical patient payment is collected monthly vs. per visit.

**For family units with more than eight members, add the following for each additional member:

	Medical or Dental
<100%	$4,160
101%-125%	$5,200
126%-150%	$6,240
151%-175%	$7,280
176%-200%	$8,320

As approved by the AxessPointe Community Health Centers, Inc. Board of Directors on 10/26/2016.

AccessPointe Community Health Centers

Advanced Care Planning

What Is Advance Care Planning?

Advance care planning involves learning about the types of decisions that might need to be made, considering those decisions ahead of time, and then letting others know about your preferences, often by putting them into an *advance directive*. An advance directive is a legal document that goes into effect **only** if you are incapacitated and unable to speak for yourself. This could be the result of disease or severe injury—no matter how old you are. It helps others know what type of medical care you want.

Making Your Wishes Known

There are two elements in an advance directive—a living will and a durable power of attorney for health care. There are also other documents that can supplement your advance directive or stand alone. You can choose which documents to create, depending on how you want decisions to be made. These documents include:

- Living will
- Durable power of attorney for health care
- Other documents discussing DNR (do not resuscitate) orders, organ and tissue donation, dialysis, and blood transfusions

Living will. A living will is a written document that helps you tell doctors how you want to be treated if you are dying or permanently unconscious and cannot make decisions about emergency treatment. In a living will, you can say which of the procedures described on page 2 you would want, which ones you wouldn't want, and under which conditions each of your choices applies.

Durable power of attorney for health care. A durable power of attorney for health care is a legal document naming a healthcare proxy, someone to make medical decisions for you at times when you might not be able to do so. Your proxy, also known as a surrogate or agent, should be familiar with your values and wishes. This means that he or she will be able to decide as you would when treatment decisions need to be made. A proxy can be chosen in addition to or instead of a living will. Having a healthcare proxy helps you plan for situations that cannot be foreseen, like a serious auto accident. A durable power of attorney for health care enables you to be more specific about your medical treatment than a living will.

Other advance care planning documents. You might also want to prepare separate documents to express your wishes about a single medical issue or something not already covered in your advance directive. A living will usually covers only the specific life sustaining treatments discussed earlier. You might want to give your healthcare proxy specific instructions about other issues, such as blood transfusion or kidney dialysis. This is especially important if your doctor suggests that, given your health condition, such treatments might be needed in the future. Two medical issues that might arise at the end of life are DNR orders and organ and tissue donation.

If you would like more information on these topics, please ask front desk associate OR visit: **National Institute on Aging Information Center @ http://www.nia.nih.gov/**