AxessPointe
Community Health Centers

Please check which service you are registering for: ☐ **Medical** ☐ **Dental** ☐ **Both**

For patients 18 and older please complete sections 1 & 3 along with the remainder of the form.
For patients 17 and younger please complete sections 2 & 3 along with the remainder of the form.

SECTION 1: ADULT PATIENT INFORMATION

Last Name _____ First Name_____ MI _____

Address _____ City_____ State _____ Zip _____

Home Phone _____ ☐Preferred Cell Phone_____ ☐Preferred

How would you like us to contact you? ☐Call ☐Text ☐Email OK to leave a message? ☐Yes ☐No

Email Address_____

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

☐ Please check to opt out of receiving marketing communications

☐ How did you hear about AxessPointe? _____

Date of Birth ____/____/____ **Sex at birth:** ☐ Male ☐ Female **Current Gender Identity:** ☐ Trans ☐ M ☐ F ☐ Other

SSN: _____-____-_____ **Marital Status:** ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed

Do you consider yourself: ☐Gay ☐ Straight ☐Lesbian ☐ Bisexual ☐Other ☐Decline **Student Status:** ☐ Full ☐ Part ☐ Not a student

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

_____
(Employer Name and Phone Number)

Annual Household Income:
☐$0-$12,389 ☐$12,490-$16,611 ☐$16,612-$20,732 ☐$20,733-$24,980 ☐$24,981+ ☐Choose not to disclose

Race: ☐African American/Black ☐Asian ☐Caucasian/White ☐Native American ☐Pacific Islander ☐Other

Hispanic/Latino: ☐Yes ☐No **Primary Language Spoken:** _____ **Translator required:** ☐Yes ☐No

Are you a Veteran? ☐Yes ☐No **Do you currently receive Public Housing Assistance?** ☐Yes ☐No

Are you a refugee? ☐Yes ☐No **Are you a migrant?** ☐Yes ☐No

Housing arrangement: ☐ Homeless ☐ Transitional ☐ Doubling up ☐ Street ☐ Other ☐ Unknown ☐ Rent/Own

Preferred Pharmacy: _____
(Pharmacy Name) (City) (Phone Number)

Do you have a Living Will? ☐Yes ☐No **Durable Power of Attorney?** ☐Yes _____ ☐No
(Name)

DNR? ☐Yes ☐No

SECTION 2: CHILD PATIENT INFORMATION

Last Name _____ First Name _____ MI: _____

Address _____ City _____ State _____ Zip _____

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

☐ Please check to opt out of receiving marketing communications

☐ How did you hear about AxessPointe? _____

Date of Birth ____/____/____ **Sex:** ☐ Male ☐ Female **SSN:** _____-____-_____ **Student Status:** ☐ Full time ☐ Part time

Race: ☐African American/Black ☐Asian ☐Caucasian/White ☐Native American ☐Pacific Islander ☐Other

Hispanic/Latino: ☐Yes ☐No **Primary Language Spoken:** _____

Preferred Pharmacy: _____
(Pharmacy Name) (City) (Phone Number)

Select one: ☐ PARENT ☐ GUARDIAN

Mother's/Guardian's Name: _____ Date Of Birth _____

Mother's/Guardian's Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ OK to leave message ☐Yes ☐No SSN#: _____

Mother's/Guardian's E-Mail address: _____

Select one: ☐ PARENT ☐ GUARDIAN

Father's/Guardians Name: _____ Date Of Birth _____

Father's/Guardian's Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ OK to leave message ☐Yes ☐No SSN#: _____

Father's/Guardian's E-Mail address: _____

The following people are authorized to bring the patient (minor/disabled) to clinic visits:

Name	Relationship	Phone

SECTION 3: EMERGENCY CONTACT

☐ Same as parent/guardian

Name: _____ Relation: _____ Phone: _____

Address: ☐ Same as patient: _____

Please list any persons you authorize the clinic to leave personal medical information with: (optional)

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

PATIENT INSURANCE COVERAGE – MEDICAL

Primary Insurance: _____ Subscriber Name: _____

Subscriber Birth Date: _____ Subscriber Social Security #: _____

Relationship to patient: _____ ID#: _____ Group #: _____

Secondary Insurance: _____ Subscriber Name: _____

Subscriber Birth Date: _____ Subscriber Social Security #: _____

Relationship to patient: _____ ID#: _____ Group #: _____

PATIENT INSURANCE COVERAGE – DENTAL

Primary Insurance: _____ Subscriber Name: _____

Subscriber Birth Date: _____ Subscriber Social Security #: _____

Relationship to patient: _____ ID#: _____ Group #: _____

Secondary Insurance: _____ Subscriber Name: _____

Subscriber Birth Date: _____ Subscriber Social Security #: _____

Relationship to patient: _____ ID#: _____ Group #: _____

ARE YOU SELF-PAY? ☐ Yes ☐ No (A sliding-fee discount scale is available based on income and family size)

☐ 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.

I hereby authorize the release of any medical/dental information necessary for the processing of third party payers. I also authorize insurance benefits to be paid directly to AxessPointe Community Health Centers, Inc. I understand that if my insurance does not pay, I am responsible for payment of services provided.

Signature: _____ Date: _____

Relationship to Patient (please select one): ☐ Self ☐ Parent/Guardian ☐ Power of Attorney

AxessPointe
Community Health Centers

Patient Name:_____ **SS#**_____ **DOB:**_____

CONSENT TO TREATMENT: I request the employees, agents and staff of AxessPointe Community Health, Inc. (API) to perform and hereby consent to such medical, dental and behavioral health care and treatment to the patient named above as may be deemed necessary and/or advisable in the judgment of my/the patient's treating provider(s). This may include diagnostic, radiology and laboratory procedures, and medication administration. I understand that I have the right to refuse consent to any proposed procedure or treatment at any time prior to its performance.

I understand that API is a training site for medical, dental and auxiliary students. I hereby authorize and permit such to participate in my/the patient's 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.

I understand that my medical provider may request that an API pharmacist be used in the management of my/the patient's care. I understand that I or an individual authorized to act on my behalf may elect to participate in or withdraw from the service provided by the API pharmacist.

NO GUARANTEE: I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of any procedures, treatments or examinations.

FINANCIAL RESPONSIBILITY: In consideration of medical, dental and or behavioral health services to be received by me, I assign, transfer, and agree to have API be directly reimbursed by my/the patient's 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/the patient by API. If my/the patient's 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/the patient by API.

RELEASE OF INFORMATION: I authorize API to release any and all patient medical, dental and billing information to any physician involved in my/the patient's treatment; to any pharmacy or other health care facility to which I/the patient is referred for treatment; to any entity which performs billing, quality assurance, collection or defense of litigation or anticipated litigation on behalf of API; 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/the patient's protected health information to carry out treatment, payment or health, behavioral or dental care operations by API.

HEALTH INFORMATION EXCHANGE: Health information exchange allows health care providers to share health care information about patients electronically for several purposes, such as treatment, quality assurance and state law reporting requirements. I understand that if I go to the Practice for treatment, the physicians and/or their staff may get a copy of my medication history and other health care information electronically through various health information exchange connections with other health care providers.

I understand I may request that my health care information not be shared through electronic health information exchange by following the directions in API's Notice of Patient Privacy Practices.

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.

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.

AUTHORIZATION TO OBTAIN EXTERNAL PRESCRIPTION HISTORY: I authorize API to view my external prescription history. I understand that this prescription history may contain records from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff at API. I also understand that it may include prescriptions from several years ago.

_____

Patient or Legal Representative Signature & Date

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 Representative Signature & Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & PATIENT RIGHTS AND RESPONSIBILITIES: I acknowledge that I have been provided a copy of the API Notice of Privacy Practices, which describes how health information about me may be used and disclosed by API and how I may obtain access to and control the use and disclosure of this information. I have also received a copy of the Patient's Bill of Rights and Responsibilities. I have read, or had read to me, the Bill of Rights and I understand my rights and responsibilities. I agree to participate actively in my care in accordance with these rights and responsibilities.

_____

Patient or Legal Representative Signature & Date

HEALTH INFORMATION EXCHANGE: I acknowledge that API participates in the CliniSync Health Information Exchanges. This allows AxessPointe and other healthcare providers to access your health information through the Health Information Exchange for treatment, payment or other healthcare operations. You may opt-out of participation in the CliniSync Health Information Exchange by checking the box below or notifying API's Medical Records department or CliniSync at any time.

☐ I choose to opt out of participation in the CliniSync Health Information Exchange. I may opt-in by contacting the AxessPointe Medical Records department or CliniSync directly.

_____

Patient or Legal Representative Signature & Date

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

BY SIGNING BELOW, I AM AGREEING TO THE CONSENTS AND RELEASES DESCRIBED ON THIS FORM. I HAVE READ THIS CONSENT AND HAVE BEEN ABLE TO ASK QUESTIONS.

_____ _____

Patient or Legal Representative Signature & Date **API Staff (witness) Signature & Date**

_____

Legal Representative Relationship (if applicable)

AccessPointe
Community Health Centers

Sliding-Fee Scale Application

PERSONAL INFORMATION

Last name: _____ First name: _____ MI: ____

Date of birth: ____/____/____ Social security number: _____

Home address: _____

_____ Phone number (cell): _____

City/State: _____ Zip_____ Phone number (home): _____

HOUSEHOLD INFORMATION

Name of spouse: _____ Date of birth: ____/____/____

Social Security: _____

List dependents claimed on your tax return:

Name	Social Security No.	Date of birth	Relationship
_____	____-____-____	____/____/____	_____
_____	____-____-____	____/____/____	_____
_____	____-____-____	____/____/____	_____
_____	____-____-____	____/____/____	_____
_____	____-____-____	____/____/____	_____

PROOF OF INCOME

You must bring proof of income: ☐ Most recent tax return/4506-T ☐Notarized letter of support

☐ SS/Disability award letter ☐ Unemployment award letter ☐Alimony/child support decree

☐ Last 3-4 paystubs from each member of house ☐ Other _____

- I have completed this application for sliding-fee eligibility and confirm that all information is correct to the best of my knowledge.

_____ _____

Applicants Signature Date

ELIGIBILITY INFORMATION – FOR OFFICE USE ONLY

Annual gross income $_____ Number of dependents ____ Start Date_____ End Date_____

☐ Application approved ☐ Slide A ☐ Slide B ☐ Slide C ☐ Slide D

☐ Application denied – **RESPONSIBLE FOR 100% OF CHARGE**

Processed by: _____ Date: _____

AccessPointe Community Health Centers

2019

Effective 1/1/2019 Updated 1/31/2019

Based on HHS 2019 Federal Poverty Guidelines

Medical, Pharmacy & Dental Program Sliding Fee Discount Guidelines

		A *(See Note 1)*	B	C	D	E
MEDICAL/BEHAVIORAL	Pt. Pays	Nominal Fee $15	Flat Fee $25	Flat Fee $50	Flat Fee $75	Full Charge
PHARMACY	Pt. Pays	Nominal Fee $5	Flat Fee $10	Flat Fee $15	Flat Fee $20	Full Charge
DENTAL	Pt. Pays	Nominal Fee $35	Flat Fee $50	Flat Fee $80	Flat Fee $115	Full Charge
	% of FPL	≤ 100%	>100%-133%	>133%-166%	>166%-200%	>200%
	1	$ 12,490	$ 16,612	$ 20,733	$ 24,980	$ 24,981
	2	$ 16,910	$ 22,490	$ 28,071	$ 33,820	$ 33,821
	3	$ 21,330	$ 28,369	$ 35,408	$ 42,660	$ 42,661
	4	$ 25,750	$ 34,248	$ 42,745	$ 51,500	$ 51,501
	5	$ 30,170	$ 40,126	$ 50,082	$ 60,340	$ 60,341
	6	$ 34,590	$ 46,005	$ 57,419	$ 69,180	$ 69,181
	7	$ 39,010	$ 51,883	$ 64,757	$ 78,020	$ 78,021
	8*	$ 43,430	$ 57,762	$ 72,094	$ 86,860	$ 86,861

Note 1: 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 8 members, add the following for each additional member:*

MEDICAL, PHARMACY & DENTAL		
≤ 100%	$	4,420
>100%-133%	$	5,879
>133%- 166%	$	7,337
>166%-200%	$	8,840
>200%	$	8,841

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/**