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Annual Registration Form

Section 1: Patient Information

First Name: _____ **Last Name:** _____ **MI:** _____

SSN: _____ **Sex assigned at birth** ☐ Male ☐ Female **Date of Birth:** _____ **Age:** _____

Home Address _____ **City** _____ **State** _____ **Zip** _____

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone: _____ **Work Phone:** _____ **Cell phone:** _____

Email Address: _____

Primary language spoken at home: _____ **Interpreter needed:** ☐ No ☐ Yes

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partner ☐ Refuse to report

Emergency Contact: _____ **Relationship to patient:** _____ **Phone:** _____

Note: Depending on the nature of the emergency and at the discretion of the provider, it may be necessary to share certain limited clinical information about you with this individual.

If under the age of 18, please provide Parent/Guardian name(s):

Please select one answer per question and provide additional information when required:

Are you a student? ☐ No ☐ Full Time Student ☐ Part Time Student Are you a veteran: ☐ No ☐ Yes

Are you a migrant farm worker? ☐ No ☐ Yes ☐ Seasonal

Are you Hispanic, Latino or Chicano? ☐ No ☐ Yes ☐ Refuse to report

Please check which of the following best describes employment status.

☐ Employed Full Time ☐ Employed Part Time ☐ Unemployed ☐ Self Employed ☐ Retired ☐ Other

Please check which of the following best describes your current housing. Please select only one.

☐ Home-owner /Renter ☐ Transitional housing ☐ Homeless shelter ☐ Permanent Supportive Housing ☐ Living on the streets

☐ "Doubling up" with friends or family ☐ Public housing ☐ Other – please specify:

Please check which of the following best describes your race. Please select only one.

☐ White ☐ Black or African American ☐ Native Hawaiian ☐ More than one race

☐ Asian ☐ American Indian or Native Alaskan ☐ Pacific Islander ☐ Unknown, not listed, or refuse to report

Please check which of the following best describes your sexual orientation.

☐ Straight / Heterosexual ☐ Lesbian, gay or Homosexual ☐ Bisexual ☐ Don't know ☐ Something else ☐ Choose not to disclose

Please check which of the following best describes your gender identity.

☐ Male ☐ Female ☐ Transgender male / female-to-male ☐ Transgender female / male-to-female ☐ Other ☐ Choose not to disclose

Section II: Insurance and Guarantor Information

Please check the type(s) of insurance coverage that you have: ☐ Medicaid/Medicare ☐ Other Medical Insurance ☐ Dental Insurance ☐ None

Insurance Name: _____ **Policy Number:** _____ **Group Number:** _____

Insured Name: _____

Relationship to Patient: _____ **Insured Date of Birth:** _____

Insured Home Address: _____ **City** _____ **State** _____ **Zip** _____

Insured Home phone: _____ **Insured Work Phone:** _____ **Insured Cell phone:** _____

Insured Social Security # _____ **Insured Employer Name:** _____

Section III: Sliding Fee Discount Program

As a community healthcare center, HopeHealth offers a sliding fee discount to all patients. This benefit can help to lower the cost of healthcare services provided by HopeHealth and make medications more affordable at our HopeHealth pharmacy. Any patient, with or without insurance, can apply and qualification is based on income and household size. If you are interested in completing an application or would like more information, please take a moment to view the table below to see if you may qualify and select your answer. ☐ No ☐ Yes ☐ I would like more information

If your family size is:	Which of the following ranges captures your annual household income?					
	100% Poverty $20 Copay	125% Poverty $30 Copay	150% Poverty $35 Copay	175% Poverty $40 Copay	200% Poverty $45 Copay	>200% Poverty
1 →	$0-$13,590	$13,591-$16,988	$16,989-$20,385	$20,386-$23,783	$23,784-$27,180	>$27,180
2 →	$0-$18,310	$18,311-$22,888	$22,889-$27,465	$27,466-$32,043	$32,044-$36,620	>$36,620
3 →	$0-$23,030	$23,031-$28,788	$28,789-$34,545	$34,546-$40,303	$40,304-$46,060	>$46,060
4 →	$0-$27,750	$27,751-$34,688	$34,689-$41,625	$41,626-$48,563	$48,564-$55,500	>$55,500
5 →	$0-$32,470	$32,471-$40,588	$40,589-$48,705	$48,706-$56,823	$56,824-$64,940	>$64,940
6 →	$0-$37,190	$37,191-$46,488	$46,489-$55,785	$55,786-$65,083	$65,084-$74,380	>$74,380
7 →	$0-$41,910	$41,911-$52,388	$52,389-$62,865	$62,866-$73,343	$73,344-$83,820	>$83,820
8 →	$0-$46,630	$46,631-$58,288	$58,289-$69,945	$69,946-$81,603	$81,604-$93,260	>$93,260
9 →	$0-$51,350	$51,351-$64,188	$64,189-$77,025	$77,026-$89,863	$89,864-$102,700	>$102,700
10 →	$0-$56,070	$56,071-$70,088	$70,089-$84,105	$84,106-$98,123	$98,124-$112,140	>$112,140
HopeHealth Pharmacy Discount	95% Discount	90% Discount	85% Discount	80% Discount	75% Discount	No SFS Discount

Section IV: Other Required Information

Are you a current patient at HopeHealth? ☐ Yes ☐ No If yes, who is your HopeHealth provider?

NEW PATIENTS ONLY:
How were you referred to us?

☐ Hospital ☐ School ☐ Work ☐ Employee ☐ Family
☐ Friend ☐ Radio ad ☐ Internet ☐ Billboard ☐ Other
☐ Physician *Name of referring Physician:*

Do you prefer a male provider or a female provider? ☐ Male ☐ Female ☐ No preference

I authorize release of information regarding continuation of care and/or any payments for services. I authorize a copy of the document may be used as the original document. I certify that this information is true and correct to the best of my ability.

Signed: ***Date:***

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Consent for Evaluation and Treatment

HopeHealth, Inc. (HH) is dedicated to providing excellent, compassionate care for South Carolina residents by offering a wide range of integrated health services. Because we believe the best care is given when health care providers work together, HH patients may be referred to providers from other health care specialties within the HH treatment team. Members of the treatment team will share information and consult with each other in order to provide the best care for the Patient.

HH staff and providers will depend on statements provided by Patient, Patient's medical history, and other available information to evaluate his/her condition and decide on the best treatment. Patient acknowledges that HH staff and providers may obtain information necessary for quality assurance, care coordination and other health care operations purposes. The evaluation and treatment of children and adolescents requires the involvement of parent(s) and/or other family members. It is important that Patient is actively involved in developing the treatment plan.

Care may be provided at HopeHealth using a variety of methods, including, but not limited to, in-person appointments, telemedicine, telephone, etc. Sometimes a clinical trainee supervised by HH staff or providers may be involved in Patient's care. Patient will be informed if a trainee is involved in care. Patient consents to the use of virtual scribe services as it relates to documenting patient's care in their medical records.

Health care is not an exact science, and no guarantees are made concerning the course or effect of treatment proposed by the provider or about outcomes of treatment. In behavioral health care, symptoms may get worse before improvement occurs. Any questions about the benefits, risks, available options, or the limits of confidentiality should be directed to the treatment staff.

In treating patients, studies including x-rays, laboratory tests, EKGs or psychological tests may be warranted. There are risks involved in taking any medications and any questions about medications will be answered by the medical staff. Patient accepts the risks of medication and other treatment.

Financial Arrangements: There are fees for all services and Patients should pay on the day the Patient is seen. Health insurance policies may cover a portion of the fees. Patient shall tell HH staff about changes in financial status including insurance. HH is available to assist patients with understanding healthcare benefits. Assistance can be requested for Patients that may qualify for our Sliding Fee Discount program.

Patient Discharge Policy: HopeHealth strives to maintain a safe environment for our patients, staff, and visitors. Any behavior that would result in harm to a person while on HopeHealth property may be cause for immediate discharge from our services. Patients are expected to call in advance if for any reason an appointment cannot be kept. Patient understands that multiple missed appointments and/or failure to comply with plan of care may result in a decision to terminate the provider/patient relationship. Should it become necessary to discharge a patient for any of these reasons, HH will assist in the transition of care to another provider within reason. Patients who have been discharged may request to be reinstated after a period of no less than six (6) months.

Notice of Privacy Practices: HopeHealth exercises its best efforts to protect the privacy and security of its patients' health information and to limit use and disclosure of patient information consistent with the law. The HopeHealth Notice of Privacy Practices sets forth the manner in which the protected health information of the patient may be used or disclosed by HH and outlines the patient's applicable rights with respect to such information. A paper copy of the Notice of Privacy Practices is provided to each new patient upon initial registration. The Notice of Privacy Practices is also posted prominently in the waiting area at each office and on the HopeHealth website. A paper copy of is made available to the patient upon request and Patient acknowledges that a copy has been offered.

HopeHealth recommends HIV testing for our patients as part of routine screenings. This screening is performed at no cost to our patients. If you choose to decline this testing, please initial here: _____.

By signing this form, I agree that I have read or had this form read and/or explained to me, that I understand it and that any questions I asked have been answered. I agree to be truthful in providing information to assist in my healthcare.

I also understand that HopeHealth is an integrated care system, meaning that all providers work together to coordinate my care. I understand that all of my visit notes are part of my HopeHealth medical record. This means that other providers who care for me at HopeHealth may have access to this information.

Thus, I hereby ask, agree, and consent to evaluation and treatment for myself and/or my child(ren) as set forth above, including any studies or procedures that HH professional staff decide are necessary or appropriate. If signing as parent or guardian, I hereby represent and warrant that I am legally empowered and entitled to make such decisions.

_____	_____	_____
Patient's or Guardian's Signature	Type or Print Name	Date
_____		_____
Witness		Date

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Patient Designation of Personal Representative(s)

Patient Name	Date of Birth	XXX-XX- Last four digits of SSN	Today's Date

I. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:
The individual(s) identified below are involved in my healthcare and may inquire about my health and/or related billing information on my behalf, and I authorize HopeHealth to disclose to them such information as may be necessary based upon their involvement in my healthcare. I understand that I may direct HopeHealth to add or remove individuals at any time and that while the changes will take effect immediately upon receipt, disclosures made prior to any revocation are not affected. I understand that HopeHealth is not liable for any misuse of my personal health and billing information by those whom I have authorized below.

Name: _____ Relationship: _____ Date of Birth: _____ Phone: _____

Name: _____ Relationship: _____ Date of Birth: _____ Phone: _____

Name: _____ Relationship: _____ Date of Birth: _____ Phone: _____

II. Acknowledgement of HopeHealth Notice of Privacy Practices:
I acknowledge that I have received a copy of the HopeHealth Notice of Privacy Practices (NPP) which sets forth my rights relating to the use and disclosure of my personal health information and explains how HopeHealth may use and/or disclose my personal health information, and that I have read (or had the opportunity to read if I so chose) and understand the NPP and agree to its terms.

Name of Patient	***Signature of Patient or Responsible Party***	***Date***