HOT SPRINGS HEALTH PROGRAM
Hot Springs Medical Center
Laurel Medical Center
Mashburn Medical Center
Mars Hill Medical Center

PATIENT REGISTRATION

Office Use Only
FD–Info Updated _____(initials)
FD–Form Scanned/Attached _____(initials)
Date patient contacted:_____
Date patient contacted:_____
Date Inc Lvl entered in PP:_____

Name:_____ _____ _____ **Date of Birth**:____/____/____
First Middle Initial Last

Social Security #:_____ **Sex (M/F)**:_____ **Marital Status (S/M/D/W)**:_____ **Veteran**: ___Yes ___No

Mailing Address:_____

City:_____ **State**:_____ **Zip Code**:_____

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

For patient's under 18 years of age: Mother's Name:_____ Father's Name:_____

Legal Guardian (if applicable):_____ **Person Responsible for Payment**:_____

Person (not living in your household) to contact in case of emergency: Name:_____

Relationship:_____ Home #:_____ Cell #:_____ Work #:_____

Primary Insurance Information

Insurance Co. Name:_____ **ID#**:_____ Group#_____

Address:_____ City:_____ State:_____ Zip:_____

Policy Holder Name:_____ Policy Holder DOB:_____ Sex:_____

Relationship to Policy Holder:_____ Employer Name:_____

*TriCare – Sponsor's SSN:_____

Secondary Insurance Information

Insurance Co. Name:_____ **ID#**:_____ Group#_____

Address:_____ City:_____ State:_____ Zip:_____

Policy Holder Name:_____ Policy Holder DOB:_____ Sex:_____

Relationship to Policy Holder:_____ Employer Name:_____

*TriCare – Sponsor's SSN:_____

Third Insurance Information

Insurance Co. Name:_____ **ID#**:_____ Group#_____

Address:_____ City:_____ State:_____ Zip:_____

Policy Holder Name:_____ Policy Holder DOB:_____ Sex:_____

Relationship to Policy Holder:_____ Employer Name:_____

*TriCare – Sponsor's SSN:_____

Occasionally, we send out patient wellness reminders or information about our services. Please indicate your preferred method of contact for this information. *If no preference is marked, HSHP will use the portal/email as the default contact method if a valid email address is on file.*

☐Mail ☐Phone ☐Portal/Email

The following information is requested by the Federal Government in order to monitor compliance with Federal laws prohibiting discrimination against patients seeking care from organizations receiving USDA funding. You are not required to furnish this information, but are encouraged to do so. This information will not be used to discriminate against you in any way. However, if you choose not to furnish it, we are required to note the race/national origin of the individual patient on the basis of visual observation or surname.

☐ I do not wish to furnish this information.

ETHNICITY: ☐ Not Hispanic or Latino ☐ Hispanic or Latino

RACE: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Data used by HSHP (a Federally Qualified Health Center Look-Alike) in determining potential qualification for Sliding Fee Discount and other assistance programs as well as reporting. *If not completed, you will not be eligible for potential discount.* Someone will discuss with you your potential qualification today or contact you within one (1) week.

☐ I do not wish to furnish this information. ☐ Medicaid is my primary insurance.

Number of Persons in Home (circle one): 1 2 3 4 5 6 7 8 9 10 Other:_____

Household Income Range (circle one): < $11,880 $11,881-15,799 $15,800-23,759 $23,760-32,038 $32,039-40,318 $40,319-48,598 $48,599-56,877 $56,878-65,157 $65,158-73,456 $73,457-81,776 $81,777+

STATEMENT OF CONSENT FOR TREATMENT

I hereby voluntarily consent to routine medical treatment by the staff of the Hot Springs Health Program and their agents. If the patient is a minor who I am responsible for and/or the parent or legal guardian, I consent to routine medical treatment of my child. Further, I understand that specific and separate consent forms may be requested from me prior to any non-routine or hazardous treatment that is not an emergency.

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT

I hereby assign my benefits and request payment of benefits for services rendered to me or on my behalf to be paid to the Hot Springs Health Program, Inc. I also authorize release of medical information to my insurance company if needed to determine eligibility of these benefits or benefits of related services. By request of the Hot Springs Health Program, Inc., payment is requested at time of service, unless other arrangements have been made in advance. Hot Springs Health Program is not contracted and does not accept assignment with all insurance companies. Insurance will be filed as a courtesy for our patients. This financial agreement is between the Hot Springs Health Program, Inc., and the undersigned party. As the undersigned, I acknowledge responsibility for any remaining balances after insurance has been filed or for any non-covered services by the insurance company. The undersigned is ultimately responsible for payment.

PRIVACY PRACTICES NOTIFICATION

I have had the opportunity to view or obtain a copy of the Hot Springs Health Program's Notice of Privacy Practices as required by the federal Health Insurance Portability and Accountability Act.

PATIENT'S RESPONSIBILITY

"I verify the accuracy of the aforementioned information and I authorize the release of information as provided above."

"I agree that I am fully responsible to pay all fees charged by the provider, regardless of how much my insurance pays. I acknowledge that the provider may not be contracted nor accept assignment with my insurance carrier. If the provider accepts assignment, the deductible and co-payments are my responsibility."

"I UNDERSTAND THAT ALL COPAYS ARE TO BE PAID AT THE TIME OF SERVICE."

Signature:_____ Date:_____

Patient Signature (If less that 18yrs old, parent or legal guardian signature)