Welcome to Southern Nevada Community Health Center!

New Patient Registration Form

Section 1

As a Federally Qualified Health Center, we are required to collect demographic information regarding the patients we serve. The information you provide is confidential. Please check "Choose not to disclose" if you do not wish to answer a specific question.

Patient / Client Information

Last Name:	First Name:	Middle Name:	DOB / /
Address:		Apt/Unit:	**Sex Assigned at Birth:** ☐ Male ☐ Female
City:	State:		Zip Code:

Main Phone:	**Cell Phone:**	**Email:**
OK to Leave Message? ☐ Yes ☐ No	OK to Text? ☐ Yes ☐ No	

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Partner ☐ Widowed ☐ Legally Separated ☐ Choose not to disclose

Primary Language:

Do you need an interpreter? ☐ Yes ☐ No
Hearing Impaired or need sign language interpreter services? ☐ Yes ☐ No

Race: ***Check all that apply***

☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander
☐ African American / Black ☐ American Indian or Alaska Native ☐ Caucasian / White
☐ Choose not to disclose

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Choose not to disclose

US Veteran ☐ YES ☐ NO **Migratory agricultural** ☐ YES ☐ NO **Seasonal agricultural** ☐ YES ☐ NO

Living Arrangements:

☐ Permanent Residence (own, rent apartment/room/house) ☐ Transitional Housing (center, community, home)
☐ Shelter (safe havens, temporary overnight housing, armories) ☐ Permanent Supportive Housing
☐ Doubling up (living with other people for a temporary period) ☐Other:

Sexual Orientation:

☐ Lesbian or Gay ☐ Straight ☐ Bisexual
☐ Something else ☐ Don't know ☐ Chose not to disclose

Gender Identity:

☐ Male ☐ Transgender Male (Female to Male) ☐ Other: ______________________
☐ Female ☐ Transgender Female (Male to Female) ☐ Chose not to disclose

Emergency Contact

Name:	Phone:
Relationship: ☐ Parent ☐ Guardian ☐ Spouse ☐ Other:	

We care about your privacy

INFORMATION NECESSARY TO RECEIVE CONFIDENTIAL INFORMATION (test results, etc.) ON THE PHONE:

MOTHER MAIDEN NAME:	PASSWORD:

Acknowledgement of Information

PRINT NAME:	SIGNATURE:
Relationship: ☐ Self ☐ Parent / Guardian	DATE:

Approved Form (Rev.07/2020)

Staff Initials____________

Insurance Information

Section 2

Please provide identification and insurance cards at the time of registration.

Do you have: Any Medical Insurance: ☐ Yes ☐ No

If yes, mark all that apply:

☐ Medicaid ☐ Medicare ☐ Health Plan of Nevada ☐ Culinary ☐ Cigna
☐ Aetna ☐ Tricare ☐ Silver Summit Health Plan ☐ HPN Medicaid/Nevada Check-Up
☐ Anthem Blue Cross Blue Shield ☐ Hawaii Mainland Administrators
☐ Healthcare Partners of Nevada ☐ One Health
☐ Teachers Health Trust ☐ Prominence Health Plan HMO
☐ Multiplan (includes subsidiary Beechstreet) ☐ Managed Care Contracts
☐ Sierra Health & Life Insurance Co. ☐ Other: ______________________________

Is it OK to bill your insurance? ☐ Yes ☐ No *If no, please explain why?* ______________________________
(If we do not bill for services, you will be responsible to pay the full fee associated with you visit).

Is it OK to mail letters/billing statements to your home address? ☐ Yes ☐ No
If no, provide a mailing address/email of your choice.

Primary Insurance Company	Insured (Name on the Insurance Card)	**Relationship to patient:** ☐ Self ☐ Spouse/Partner ☐ Parent/Guardian ☐ Other
Name of Employer	Insured's Date of Birth	Group Number
Insurance Co. Contact Number (On the back of card)		ID Number

☐ Check if Address/Phone Same as Above. If different please complete: Phone (   )
Street: City: State: Zip Code:

Secondary Insurance Company	Insured (Name on the insurance Card)	**Relationship to patient:** ☐ Self ☐ Spouse/Partner ☐ Parent/Guardian ☐ Other
Name of Employer	Insured's Date of Birth	**Group Number**
Insurance Co. Contact Number (On the back of card)		ID Number

☐ Check if Address/Phone Same as Above. If different please complete: Phone (   )
Street: City: State: Zip Code:

Responsible Party or Guarantor

PRINT NAME:	SIGNATURE:
Relationship: ☐ Self ☐ Parent / Guardian ☐ Spouse/Partner ☐ Other	DATE:

☐ Check if Address/Phone Same as Above. If different please complete: Phone (   )
Street: City: State: Zip Code:

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Sliding Fee Application

Section 3

In order for SNCHC to help our patients, we must ask everyone to complete the following information. This is requested of you so that SNCHC can receive Federal grant dollars to serve our patients. We appreciate your cooperation.

Income Information: If you are eligible, fees for service may be discounted according to a sliding fee scale. You must provide us with proof of income to determine the sliding fee scale level.

☐ **I decline the Sliding Fee Scale Discount Program.**

☐ I have no Income ☐ I am unemployed ☐ I am homeless ☐ I am self-employed		**Office Use Only**
What is your weekly income before taxes? Hourly Rate ____ Number of hours you work per week _____	$	Sliding Fee Category __________
What is your partner/spouse's weekly income before taxes? Hourly rate of pay _____ Number of hours you work per week _____	$	
If you live with and/or are supported by your parents and they are aware of your visit, what is their weekly income before taxes?	$	
Other types of income: ☐ Alimony ☐ Child Support ☐ Social Security ☐ ADC ☐ Disability ☐ Pension ☐ Retirement ☐ Welfare Assistance ☐ Second Part-Time Job ☐ Other Income: ________________________	$	☐ Referred to Eligibility Specialist
If you do not have income, please explain how your basic needs are paid for:	$	
How many people are supported by this income?		

No patient will be denied services due to inability to pay.
Please ask to speak to a Eligibility Specialist about your options in the event you are unable to pay your account balance.

LEVEL	P-0 100% or LESS	P-1** 101% to 150%	P-2** 151% to 175%	P-3** 176% to 200%	P-4** Over 200%
Size of Family 1	$0 - $12,760	$12,761 - $15,950	$15,951 - $19,140	$19,141 - $25,520	$25,521+
2	$0 - $17,240	$17,241 - $21,550	$21,551 - $25,860	$25,861 - $34,480	$34,481 +
3	$0 - $21,720	$21,721 - $27,150	$27,151 - $32,580	$32,581 - $43,440	$43,441 +
4	$0 - $26,200	$26,201 - $32,750	$32,751 - $39,300	$39,301 - $52,400	$52,401 +
5	$0 - $30,680	$30,681 - $38,350	$38,351 - $46,020	$46,021 - $61,360	$61,361 +
6	$0 - $35,160	$ 35,161 - $43,950	$43,951- $52,740	$52,741 - $70,320	$70,321 +
7	$0 - $39,640	$39, 641 - $49,550	$49,551 - $59,460	$59,461 - $79,280	$79,281 +
8	$0 - $44,120	$44,121 - $55,150	$55,151 - $66,180	$66,181 - $88,240	$88,241 +
For families/households with more than 8 persons, add $4,480 for each additional person.					
Based on 2020 Poverty Guidelines published 1/17/2020					

PRINT NAME:_______________________________ SIGNATURE: ______________________ DATE: ____________

Relationship: ☐ Self ☐ Parent/Guardian

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Staff Initials___________

Consent for Treatment and Services

SOUTHERN NEVADA Community HEALTH CENTER

SNHD Southern Nevada Health District

_______ ***(Initial)*** **CONSENT FOR TREATMENT:** I authorize SNCHC and its medical, nursing and other staff, to provide such health care services and administer such diagnostic and therapeutic procedures and treatments as, in the judgment of SNCHC medical personnel, is deemed necessary or advisable. This includes all routine diagnostic tests and procedures, including administration and/or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examination. I understand that no guarantees have been made to me as to the results or effectiveness of treatments or examinations performed by SNCHC personnel. I understand that I have the right to refuse consent to any proposed care, treatment, testing, surgery, or procedure. After evaluation, if my medical condition is beyond the capacity of SNCHC services, I will be referred elsewhere for further care.

______***(Initial)*** **VACCINE CONSENT:** I have read or have had explained to me the information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated on the Vaccine Administration Record be given to me or to the person named above for whom I am authorized to make this request.

_____***(Initial)*** **RELEASE OF INFORMATION:** We offer confidential services to all our clients. This means we will not release protected health information (PHI) about your visit to a friend, parent, guardian or relative without your permission. I authorize SNCHC to use and disclose my health information to provide for, arrange or coordinate my health care treatment, enable SNCHC to obtain payment for the services it provides to me; and permit SNCHC to carry out ordinary health care and business operations. The information I authorize to release may include infectious or contagious disease information, including HIV or AIDS-related information, diagnosis or treatment information; information about drug or alcohol abuse or treatment, and/or psychiatric or psychological information.

I understand that if I am treated for or diagnosed with a sexually transmitted infection or infectious disease, SNCHC is required by law to report this to public health agencies. I understand that clinic staff may also be required by law to report some claims of physical or sexual abuse.

___***(Initial)*** **NOTICE OF PRIVACY PRACTICE:** I acknowledge that a copy of the "NOTICE OF PRIVACY PRACTICE" has been made available to me.

___***(Initial)*** **PATIENT RIGHTS & RESPONSIBILITIES:** I acknowledge that my healthcare is a partnership between SNCHC Clinics and me; hence, I agree to actively participate and accept both my role and responsibility about my healthcare and the rights available to me. I have received the Patient Rights and Responsibilities notice.

_____ ***(Initial)*** **RESPONSIBILITY FOR PAYMENT & ASSIGNMENT OF BENEFITS:** I assign to SNCHC all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers and other third parties who are financially liable for the medical care and treatment provided by SNCHC. I agree, that, except as may be limited by law or SNCHC'S agreements with third party payers, in the event of non-payment by a third party for which I have provided an assignment of benefits, I am obligated to pay all amounts due for services provided at SNCHC facilities in accordance with the rates and terms of SNCHC in effect on the date of service. I also agree that I am responsible for any applicable copayments, coinsurance or deductibles.

______________________________	______________________	____________
Print Name	**Signature**	**Date**

Relationship: [ ] Self [ ] Parent [ ] Guardian [ ] Other ________________________________

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