Community Health Centers of Southeastern Iowa, Inc. (CHC/SEIA)
ANNUAL REGISTRATION FORM

PATIENT INFORMATION

NAME (LAST, FIRST, MIDDLE)	PREVIOUS/NICKNAME/AKA	SSN#	BIRTHDATE	SEX
				M F

DEMOGRAPHICS

PRIMARY ADDRESS (street name and/or P.O. Box)

CITY, STATE, ZIP

PRIMARY PHONE NUMBER	ALTERNATE PHONE NUMBER

EMAIL ADDRESS:
_____.com

REFERRED BY:	PREVIOUS PROVIDER:

ETHNICITY (Circle one)
a) Hispanic/Latino **b) Not Hispanic/Latino** **c) Unreported or refuse to report**

RACE (Circle one)
Asian **Native Hawaiian** **Other Pacific Islander** **Black/African American** **White**
American Indian/Alaska Native **More than one race** **Unreported or refuse to report**

VETERAN: YES NO

EMERGENCY CONTACT NAME/CONTACT NUMBER OF SOMEONE NOT LIVING IN HOUSEHOLD: _____ /_____ /_____
Name of Emergency Contact **Relationship to Patient** **Contact Phone Number**

INSURANCE

GUARANTOR IS PATIENT	GUARANTOR (name on insurance card)	SSN# of Guarantor	BIRTHDATE of Guarantor
*YES NO			
GUARANTOR ADDRESS SAME AS PATIEN	**PRIMARY ADDRESS of Guarantor if different than Patient**	**CITY, STATE, ZIP**	
*YES NO			

* if YES, proceed to next section

☐ **Copy of insurance card(s) attached. If current card(s) obtained/attached, you may skip Primary/Secondary Insurance section.**

PRIMARY INSURANCE ~ NAME OF INSURANCE COMPANY

NAME OF INSURANCE COMPANY	POLICY # / INSURED I.D.	GROUP #
ADDRESS OF INSURANCE COMPANY (street name and/or P.O. Box)	**CITY, STATE, ZIP**	

PHONE # INSURANCE CO	EFFECTIVE DATE	NAME OF INSURED	RELATIONSHIP TO PATIENT

SECONDARY INSURANCE ~ NAME OF INSURANCE COMPANY

NAME OF INSURANCE COMPANY	POLICY # / INSURED I.D.	GROUP #
ADDRESS OF INSURANCE COMPANY (street name and/or P.O. Box)	**CITY, STATE, ZIP**	

PHONE # INSURANCE CO	EFFECTIVE DATE	NAME OF INSURED	RELATIONSHIP TO PATIENT

SLIDING FEE DISCOUNT ~ A sliding fee discount is determined by the household size and documented total gross income of the household. A household is defined as one or more individuals who are living together sharing expenses and income.

Do you wish to be evaluated for a discount? YES* NO
* Income Verification Form to be completed and placed with income documentation

The information related to my income, insurance and identifying data is correct. If I intentionally provide CHC/SEIA with false information, it is considered fraud against the United States Government and could result in denial of future assistance.

I have been offered the CHC/SEIA Sliding Fee Discount.

_____
Signature of Patient (**or Parent, Guardian or Legal Representative) Date

NOTICE OF PRIVACY & PATIENT BILL OF RIGHTS

I certify that I am 18 years of age or older: YES NO

I have been informed of my "Rights to Privacy" and "Patient Bill of Rights" and have received or declined a copy of these patient rights.

_____
Signature of Patient (**or Parent, Guardian or Legal Representative) Date

HEALTH INSURANCE AUTHORIZATION

I hereby authorize Community Health Centers of Southeastern Iowa, Inc. (CHC/SEIA) to request payment for services provided for my insurance benefits or health plan benefits payable for services rendered to this patient. I agree that such payments should be made payable to CHC/SEIA. I hereby authorize all attorneys to make direct payment to CHC/SEIA for services rendered to be by CHC/SEIA for any settlement of judgment recovered relating to an accident for which I receive medical treatment. CHC/SEIA may request payment from the following groups which include, but are not limited to, Medicaid, Medicare, Blue Cross/Blue Shield, other insurers, health maintenance organizations and Workers Compensation. I agree to pay for all services not covered by these carriers.

Further, I authorize CHC/SEIA to disclose all or any part of the patient's record to any party who may be responsible for all or any part of the patient's charges. I give specific authorization that if my records contain information regarding the diagnosis or treatment of STD's, chemical dependency and mental health conditions, they may be released to the following groups which include but are not limited to Medicaid, Medicare, Blue Cross/Blue Shield, other insurers, health maintenance organizations and workers receiving the information. However, any information already released may be used as stated on this consent. This release of information is limited to the persons or organizations named and does not authorize the recipient to pass the information onto another facility or to anyone else.

I have read the above Health Insurance Authorization, or it has been read to me and I understand its content.

_____
Signature of Patient (**or Parent, Guardian or Legal Representative) Date

****If patient is unable to sign:**

_____
Print Your Name (as the person signing this form) Date

Specify Your Relationship to Patient: _____

Do you have legal custody of patient: YES NO