Your Community Health Center
If you need help filling out this form, please let us know.

PATIENT REGISTRATION FORM

(Please Print)

Today's Date:	YCHC Medical Provider:	YCHC Dental Provider:

PATIENT INFORMATION

Patient's First Name: Middle Initial: Last Name:	Social Security Number:	Birth Date: / /	Age:	Sex: ❑ M ❑ F
Street Address:	City:	State:	Zip Code:	
Mailing Address: ❑ Same as above	If homeless, please state homeless Status: ❑ Doubling Up ❑ Homeless Shelter ❑ Homeless ❑ Other: _____			
Email Address:	Home Phone Number: ( )	Cell Phone Number: ( )	Work Phone Number: ( )	
May we text you for appointment reminders: ❑Yes ❑ No	Preferred Pharmacy:	Phone Number for Appointment Reminder Calls:		
❑ Parent/Guardian **OR** ❑ Spouse Information: Name:	Address: ❑ Same as above	Primary Phone Number: ( )		

Does the patient have any problems with: ❑ Vision ❑ Hearing ❑ Reading ❑ Speaking Explain:

MEDICAL INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill:	Birth date: / /	Address (if different):	Primary Phone Number: ( )	
Occupation:	Employer:	Employer Phone Number: ( )		
Patients relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Step Child ❑ Other				
Primary Medical Insurance:	❑ Medicare ❑ Medicaid	❑ Blue Cross Blue Shield	❑ Cigna	❑ Other:
Subscriber's Name:	Subscriber's SSN:	Birth Date: / /	Policy #:	Group #: Co-Payment: $
Name of **Secondary Medical Insurance** (if applicable):	Subscriber's Name:	Subscriber's SSN:	Birth Date: / /	Policy #: Group #:

DENTAL INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Primary Dental Insurance:	Subscriber's Name:		Subscriber's SSN:
	Policy #:	Group #:	Subscriber's Birth Date: / /

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Primary Phone # ( )	Secondary Phone # ( )

The above information is true to the best of my knowledge. I authorize assignment of benefits for services received to be paid directly to Your Community Health Center. I understand that I am financially responsible for any balance. I also authorize Your Community Health Center or my insurance company to release any information required to process my claims.

Signature:_____ Date: _____

Ethnicity	
	Hispanic or Latino
	Not Hispanic
	Not Reported /Refused to Repot

Race	
	Asian
	Native Hawaiian
	Other Pacific Islander
	Black/African American
	American Indian/ Alaska Native
	White (not Hispanic or Latino)
	More than one race
	Not Reported / Refuse to Report

Primary Language	
	English
	Spanish
	Russian
	Ukrainian
	Other Please Specify:

How did you hear about us?	
	Newspaper/TV/Radio Ad
	Website
	Special Event
	Employee
	Other Organization
	Friend
	Other

Education	
	Current Student?
	Full Time
	Part Time

Highest Level of Education	
	Not yet in school
	Pre-School Kindergarten
	Grade School
	Middle School
	High School
	High School Degree/ GED
	Did not complete High School
	Technical Trade School
	College
	College Graduate

YCHC is my primary medical home?	
	Yes
	No

I am using YCHC today for an urgent care nee?	
	Yes
	No

Employment Status	
	Full Time
	Part Time
	None

Employer	
Employer Name	
Employer Phone Number	

Are you a veteran?	
	Yes
	No

Patient Self Determination Act	
I have an advance directive?	
	Yes
	No

PERSON(S) WHO MAY ACCOMPANY MINOR & MAKE DECISIONS FOR MEDICAL/DENTAL/ BEHAVIORAL TREATMENT		
Name:	**Relationship:**	**Phone:**
1.		
2.		
3.		

PERSON(S) WHO MAY OBTAIN MY HEALTH INFORMATION FROM YCHC		
Name:	**Relationship:**	**Phone:**
1.		
2.		

How would you rate your health? ☐Excellent ☐Good ☐Fair ☐Poor

Are you currently under the care of a physician other than for routine care for the past six months? ☐Yes ☐No

If yes, for what condition:_____

Have you been hospitalized in the past year? ☐Yes ☐No

If yes, please explain: _____ When?_____ For how long?_____

Name of your physician: _____ Phone: (_____) _____ - _____

Address: _____ Date of last complete exam? ___/___/___

•Are you allergic to or have you adversely reacted to any of the following? ☐Yes ☐No

If yes, please check the appropriate substance: (continued on next page)

☐Aspirin	☐Tylenol	☐Amoxicillin	☐Cephalexin
☐Erythromycin	☐Tetracycline	☐Augmentin	☐Codeine
☐Clindomycin	☐Doxycyline	☐Ampicillin	☐Metal
☐Z-Pack (Zithromycin)	☐Minocycline	☐Latex	☐Sulfa Drug
☐Biazin (Clarithromycin)	☐Local Anesthetic	☐Keflex	
☐Topical Anesthetic	☐Penicillin	☐Ceclor	

•Are you aware of being allergic to any other medication or substance? ☐Yes ☐No If yes, please explain:

•Please list any medications you are currently taking including over-the counter medication:

•Have you been given or have taken or taking any of the following medications?

☐Fosamax	☐Actonel	☐Boniva	☐Bonefos	☐Aredia	☐Zometa
(Alendronate)	(Risedronate)	(Ibandronate)	(Clodronate)	(Pamidronate)	(Zoledronic Acid)

•Are you currently taking, or previously taken ☐Fen-Phen or ☐Redux? ☐Yes ☐No If yes, how often or when did you quit? __

•Do you currently smoke or have you previously smoked? ☐Yes ☐No If yes, how often do you smoke or when did you quit?__

•Do you chew Tobacco? ☐Yes ☐No If yes, how often do you chew or when did you quit?_____

•Do you drink alcohol or take any recreational drugs? ☐Yes ☐No If yes, what and how often?_____

•Were you ever told you need to take antibiotics (pre-medicate) before dental treatment? ☐Yes ☐No

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•Please check any of the following that you have had or have at present: (List is continued on next page)

Skin Issues
☐Lupus
☐Head-Neck
☐Eyes
☐Ear-Nose throat
☐Sinus Trouble

Respiratory
☐Asthma
☐Emphysema
☐Tuberculosis

Cardio Vascular
☐Mitral Valve Prolapse
☐Artificial Heart Valve
☐Rheumatic or Scarlet Fever
☐Synthetic Vascular Heart Graft
☐Infectious Endocarditis
☐Neuro-surgical Shunts
☐Portacaval Shunts
☐Heart Murmur (Organic)
☐Heart Murmur (Func./Innocent)
☐Heart Failure or Disease

Endocrine
☐Thyroid Disease
☐Diabetes

Liver Disease
☐Hepatitis A
☐Hepatitis B
☐Hepatitis C

Blood disease
☐Hemophilia
☐Leukemia
☐Sickle Cell Anemia
☐Abnormal Bleeding
☐Blood Transfusion
☐Bruise Easily

Allergy
☐Seasonal
☐Food

Other:
☐AIDS
☐Alzheimer's
☐Arthritis
☐Chlamydia
☐Drug Addiction
☐Epilepsy or Seizures
☐Fainting or Dizziness
☐Fever Blisters
☐Genital Warts
☐Gonorrhea
☐ Hemodialysis Patient w/ Fistula or Shunt
☐High Blood Pressure
☐HIV Positive
☐Hyperactivity
☐Joint Replacement
☐Kidney Trouble
☐Mental Retardation
☐Psychiatric Treatment
☐Radiation Treatment
☐Speech Problems
☐Stroke
☐Syphilis
☐Valve Replacement

☐Heart Pacemaker ☐Artificial Joints (hip, knee, etc.) ☐Yeast infections
☐Congenital Heart Lesion ☐Cancer ☐Yellow Jaundice
☐Heart Surgery ☐Chemotherapy

Do you have any disease, condition or problem not listed above that we should know about? If yes, please list:

_____

•HAVE YOU HAD A SERIOUS HEAD TRAUMA? ☐Yes ☐No If yes, please explain:_____
•ARE YOU SUBJECT TO PROLONGED BLEEDING? ☐Yes ☐No
•FOR WOMEN ONLY:
Are you taking birth control pills? ☐Yes ☐No
Are you pregnant or trying to become pregnant? ☐Yes ☐No

Dental Concerns – Reason for Visit

☐Pain ☐Bleeding gums ☐Lost filing ☐Missing teeth ☐Cleaning/Exam ☐Other:_____

Feelings about seeing dentist today:
☐Negative (pain, anxiety) ☐Normal (some anxiety) ☐Positive (no anxiety)

# of months since last visit: _____ What procedure was done:_____

Dental History

Do you use: ☐Tobacco ☐Alcohol ☐ Caffeine ☐Recreational drugs
If yes, frequency: _____
of "sugared" drinks/day (juice, soft drinks, etc.):_____
of "diet' drinks/day:_____
Other refined carbohydrates/day: _____

Family History

Any history of immediate family with heart disease, lung diseases, diabetes, etc?_____
If yes, what family member?_____
Age and health of: Mother:_____ if deceased, cause: _____
Father:_____ if deceased, cause: _____
Does either parent have dentures? ☐Mother ☐Father

Past Dental Treatment

☐Fillings ☐Crowns ☐Extraction(s) ☐Dentures ☐Root Canal(s) ☐Braces ☐Implant(s)
☐Other: _____

Current Oral Hygiene Practices (frequency and type)

Frequency of brushing _____ Type of toothbrush and toothpaste:_____
Frequency of flossing _____ Mouth rinse:_____
Frequency of cleaning/check-ups:_____

Other:_____

Patient Right & Responsibilities

As a patient of Your Community Health Center, or as the parent or guardian of a minor patient at the clinic, we want you to know your rights.

As a Patient, you have the right to:

- Receive health care that respects your cultural, psychosocial, and personal values and beliefs.
- Request a copy of any rules or regulations that relate to the conduct of patients, as provided below.
- Know your records and communications are confidential to the extent provided by law, and to expect privacy during medical treatment and care.
- Participate in any consideration of ethical issues that arise in your or your child's care.
- Refuse to be examined or treated by medical students or other clinical staff, without jeopardizing access to medical care and/or treatment.
- Refuse to serve as a research subject or receive any care or examination that is primarily for educational or informational purposes.
- Inquire of any relationship the clinic, or your physician, has with another health-care facility or educational institution, to the extent that the relationship relates to your or your child's care.
- Receive information regarding financial assistance.
- Obtain the name and specialty of the physician or other health-care providers caring for you or your child.
- Have all reasonable requests responded to promptly and adequately within clinic capacity. Please allow at least 48 hours for prescription refill requests.
- Receive sufficient information to give informed consent to treatment, to the extent provided by law, including an explanation of your condition or your child's, proposed treatments, and alternative therapies, with their respective benefits and risks.
- Make decisions regarding your health care, including the decision to refuse or discontinue treatment, to the extent permitted by law.
- Fill out advance care directives, such as a health care proxy form to designate someone to make decisions for you, in the event that you become incapable of understanding a proposed treatment or procedure, or are unable to communicate your wishes regarding you care.
- A proper assessment and management of pain and/or discomfort
- Receive prompt, life-saving treatment in an emergency without discrimination or delay based on economic or payment concerns.
- Receive an itemized statement and detailed explanation of your bill.
- Register complaints, seek solutions to problems, or file grievance with the clinic if you have concerns regarding your care.
- Primary Care Services regardless of ability to pay.

The care you receive is partially dependent upon you cooperating with your health care providers, including communicating openly and honestly, following treatment plans, and respecting the facility standards of conduct.

As a patient at Your Community Health Center, you are responsible for:

- Following all facility rules as posted inside and/or outside the clinical facility. Respecting and considering other people, employees, the property of others, and property of Your Community Health Center.
- Advising us of any changes in the following: Name, Address, Phone Number(s), Insurance Information, Income, and Family Size
- Providing accurate and complete information about current symptoms, medical history, hospitalizations, medications, care obtained outside the practice, self-care information, advance directives, and any other matters related to care.
- Following instructions that you and your care team have agreed upon. Follow through on goals for self-management of your health.
- Asking questions about your care that you may not understand or have questions about, including risks of procedures, outcomes, and costs of treatment.
- Knowing what medications or drugs you are taking, why you are taking them, and the proper way to take them according to your provider's instructions.
- Keeping scheduled appointments, arriving on time for scheduled appointments, and for calling at least 4 hours in advance to cancel when you cannot keep a scheduled appointment. YCHC reserves the right to terminate service to patients who do not show for appointments more than three times in a 12 month period.
- Attending and supervising your children while in the facility.
- Calling your pharmacy to request a refill 1 week before you run out of your prescription. If authorized by an YCHC provider, your request will be filled within 72 business hours.
- Paying bills and fees promptly as defined in the financial policies.

I have read and understand the Your Community Health Center **Patient Rights and Responsibilities** and have been given an opportunity to obtain a copy for my personal records.

_____ _____

Signature Date

All Patients

I, the undersigned, do consent for treatment as deemed necessary by the attending health care provider. I, the undersigned, do also consent to treatment by YCHC dental providers.

Initial Here ☐

****ALL CHARGES ARE DUE AT THE TIME THAT SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO THE VISIT****

I authorize ***Your Community Health Center*** to release any medical information necessary to process claims and further authorize payment of medical benefits payable directly to ***Your Community Health Center.*** I understand that ***Your Community Health Center*** will file and complete the necessary steps to collect my insurance payment. However, if my insurance doesn't respond or payment is not made within 90 days, I understand that it is my responsibility to pay for any services rendered by ***Your Community Health Center.*** I further understand that ***Your Community Health Center*** may not be contracted with my insurance plan and I agree that I am responsible for charges denied for such reasons.

Initial Here ☐

CONSENT FOR TREATMENT FOR MINOR: By signing this consent I represent that I have the legal responsibility for and authority to direct the medical treatment of the above patient, either as parent or legal guardian and I will hold harmless any attending physician or other person or entity against any claim that medical treatment provided to the above patient was not authorized. This consent includes this and subsequent office visits for which I bring this minor to this office. My permission also extends to releasing this medical record to consulting physicians if ever required to adequately diagnose and treat this minor. ***Initial Here*** ☐

RECEIPT FOR PRIVACY STATEMENT: We are committed to protecting your personal health information in compliance with the law. By signing below you are acknowledging that you have read the YCHC privacy statement and understand that upon request, you may obtain a copy of the YCHC Statement of Privacy Practices. **Initial Here** ☐

By signing below and initialing on the above lines, I have read and understand the above.

Signature:_____ Date:_____

By signing below I acknowledge that I am an employee of Your Community Health Center and I have witnessed and can verify that the above signatures/initials are of the patient/patient representative.

Witness Signature:_____ Date:_____

All requested information is for statistical purposes only and is necessary for us to continue receiving federal grants.

Sliding Fee Information

Thank you for selecting Your Community Health Center. Part of our mission for YCHC is to provide quality services to you and your family. In doing so, YCHC offers a sliding fee adjustment for patients and members of their families (as defined below) who fall below 200% of the poverty guidelines as set forth by the Federal Government. Income levels are based on total "family" income, family is defined below. The amount of the discount and the income ranges for those discounts are set by YCHC's Board of Directors and approved by the Federal Government. Income guidelines are revised annually. Current discounts and income guidelines are available at Your Community Health Center.

The sliding fee application will cover all medically necessary medical, behavioral, and dental services. The costs of procedures, labs, tests, and provider visits that are deemed medically necessary will qualify for the sliding fee discount. The costs of procedures, labs, tests and provider visits that are deemed optional, cosmetic or experimental will be the responsibility of the patient requesting the services at 100% of the regular rate charged. Even if services are ordered by a provider, it does not necessarily mean that they are medically necessary.

Definitions

Family-A family means those persons within the same household (including dependents/partner) who are applying for the sliding fee discount using their combined income.

Individual-An individual is a person 18 years old or over who has verifiable income using the list below (*).

Income Verification

Income is verified once a year. If a patient has a change in their income, it is their responsibility to notify YCHC of that change. YCHC reserves the right to verify income with an employer at any time. (*)
Patients are required to provide at least two of the following items as verification of income.

- Previous year tax return
- Previous year W-2 form(s)
- Current pay stubs (last 4 weeks, if possible)
- Lay-off notification from last employer
- Current information from unemployment office
- Denied Medicaid application and reason for denial)
- Pay Stubs from unemployment (last 4, if possible)

(Continued on next page)

If you were not required to file prior's years income tax return or you receive any of the following types of income, documentation must be submitted showing the amounts of each received by any member of the household.

- Child Support
- Food Stamps
- Welfare Assistance
- Social Security
- Unemployment
- Self-Employment Income
- Alimony
- Retirement Income
- Worker's Compensation
- Disability Income
- Any Other Income

Eligible Fees

Medical, Mental Health and Dental Services that are provided at YCHC are eligible for the sliding fee discounts. **Previous charges, OWI assessments, elective procedures and outside services are not eligible for a sliding fee discount. Deductibles are eligible for sliding fee discounts.**

Minimum Charge

There is a minimum medical, mental health and dental charge for all sliding fee visits, as approved by the YCHC Board of Directors. The minimum charge **must** be paid at the time of service regardless of insurance coverage.

Additional Information

Payment is required when services are rendered. Timeliness in completing this application is important. **Your application for the sliding fee discount will not be approved until complete documentation is received**. Until you are approved for a sliding fee discount, you will be responsible for the full charges associated with services you receive from YCHC unless any amounts are covered by other third party services. If you have any questions, staff at YCHC will assist you. Thank You!!

Family Size and Income

This is important information for our federal funding

Patient Name:

_____

Instructions: Please select the **family size** in the far left column. Then **please circle** your **income range** to the right of your selected family size (in the same row.)

Number of Household Members	Household Income	100%	101%-125%	126%-150%	151%-200%	Over 200%
		OFFICE FEE PER VISIT				
Medical Office Visit		**$20.00**	**$30.00**	**$40.00**	**$50.00**	**Full Pay**
Dental Office Visit		**$50.00**	**$65.00**	**$75.00**	**$100.00**	**Full Pay**
Behavioral Health Office Visit		**$20.00**	**$25.00**	**$30.00**	**$40.00**	**Full Pay**
1	Annual	0 - 11,770	11,771 - 14,713	14,714 - 17,655	17,656 - 23,540	23,541 +
	per month	0 - 981	981 - 1,226	1,227 - 1,471	1,471 - 1,962	1,963 +
	per week	0 - 226	226 - 283	284 - 340	341 - 451	452 +
2	Annual	0 - 15,930	15,931 - 19,913	19,914 - 23,895	23,896 - 31,860	31,861 +
	per month	0 - 1,311	1,328 - 1,659	1,660 - 1,991	1,992 - 2,655	2,656 +
	per week	0 - 306	306 - 383	384 - 460	461 - 613	613 +
3	Annual	0 - 20,090	20,091 - 25,113	25,114 - 30,135	30,136 - 40,180	40,181 +
	per month	0 - 1,674	1,674 - 2,093	2,094 - 2,511	2,512 - 3,348	3,349 +
	per week	0 - 385	386 - 483	484 - 580	581 - 773	772 +
4	Annual	0 - 24,250	24,251 - 30,313	30,314 - 36,375	36,376 - 48,500	48,501 +
	per month	0 - 2,021	2,021 - 2,526	2,527 - 3,031	3,032 - 4,042	4,043 +
	per week	0 - 466	466 - 583	584 - 700	701 - 933	934 +
5	Annual	0 - 28,410	28,411 - 35,513	35,514 - 42,615	42,616 - 56,820	56,821 +
	per month	0 - 2,368	2,368 - 2,959	2,960 - 3,551	3,552 - 4,735	4,736 +
	per week	0 - 546	546 - 683	683 - 820	821 - 1,093	1,094 +
6	Annual	0 - 32,570	32,571 - 40,713	40,714 - 48,855	48,856 - 65,140	65,141 +
	per month	0 - 2,714	2,714 - 3,393	3,394 - 4,071	4,072 - 5,428	5,429 +
	per week	0 - 626	626 - 783	783 - 940	941 - 1,253	1,254 +
7	Annual	0 - 36,730	36,731 - 45,913	45,914 - 55,095	55,096 - 73,460	73,461 +
	per month	0 - 3,061	3,061 - 3,826	3,826 - 4,591	4,591 - 6,122	6,123 +
	per week	0 - 706	706 - 883	884 - 1,060	1,061 - 1,413	1,414 +
8	Annual	0 - 40,890	40,891 - 51,113	51,114 - 61,335	61,336 - 81,780	81,781 +
	per month	0 - 3,408	3,408 - 4,259	4,260 - 5,111	5,111 - 6,815	6,816 +
	per week	0 - 786	786 - 983	984 - 1,180	1,181 - 1,573	1,574 +

For each additional household member add $4,160 annually or $338 monthly or $78 weekly.

OVER 200% _____ **YES** _____ **NO**

Sliding Fee Application

(Only need to fill out if requesting help paying for services)

Patient's Name:_____

Home Address: _____

City: _____ State: _____ County:_____Zip: _____

Sex: Female Male Date of Birth: _____ Social Security No._____

Home Phone: _____ Work Phone: _____

Employer/School:_____Occupation: _____

Employer's Address: _____

Do you have any other insurance? Yes No If yes, what kind? _____

Is your employment seasonal? Yes No

Is your employment related to agriculture? Yes No

Number of people in your household? _____

Are you eligible for Medicaid? Yes No

Annual Gross Income (all adult members of household)? $_____

Financially Responsible Party:

Name:_____Date of Birth: _____

Relationship to Patient:_____Social Security No.: ____

Home Address: _____

City:_____State:_____Zip: _____

Home Phone: _____ Cell Phone:_____

Family Size: (If additional space is needed, please add to back of page)

Name	Date of Birth	Relationship

Income:

	Current Monthly	Last 12 Months Total
Wages or Self Employment	$ _____	$ _____
Social Security/Public Assistance	$ _____	$ _____
Unemployment/Workers C o m p	$ _____	$ _____
Alimony/Child Support	$ _____	$ _____
Pensions/Retirement I n c o m e	$ _____	$ _____
Food Stamps/Welfare Assistance	$ _____	$ _____
Disability Income	$ _____	$ _____
Any Other Income	$ _____	$ _____

I declare under penalty of perjury, under laws of the State of Missouri, that all statements contained in this application and accompanying documents is true and correct, with full knowledge that all statements made in this application are subject to investigation and that any false or dishonest answer to any question may be grounds for denial of application.

I have read the Sliding Fee Application and I understand that payment is due at the time of services. If documentation of income verification is not given to YCHC within 30 days of this application, the application will no longer be valid and you must reapply. Thank you in advance for your cooperation.

Signature: _____ Date: _____

For Office Use only:

Qualifies for: _____% Discount Ineligible

Date of Determination: _____

Signature of person making eligibility determination: _____