REGISTRATION FORM

Choose an item.

Today's Date:	**PCP:**

PATIENT INFORMATION

Patient's Legal Last Name:	**First:**	**Middle:**

Previous Names Used/Alias:	**Birth Date:** / /	**Age:**	**Social Security #:**

Sex at Birth: ❑Male ❑Female ❑Other ❑ Choose not to disclose ❑Intersex ❑Not recorded on birth certificate

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

Mailing Address:	**City:**	**State:**	**Zip:**

E-Mail Address:

Race:
❑Alaskan Native
❑Pacific Islander
❑Native Hawaiian
❑Asian
❑White
❑American Indian
❑Black or African American
❑Unknown
❑Choose not to disclose

Ethnicity:
❑Hispanic ❑Not Hispanic
❑Unknown
❑Choose not to disclose

Sexual Orientation:
❑ Asexual
❑ Bisexual
❑ Lesbian or Gay
❑ Omnisexual
❑ Pansexual
❑ Straight (not lesbian or gay)
❑ Queer
❑ Something else
Don't know
❑ Choose not to disclose

Gender Identity:
❑ Female
❑ Male
❑ Transgender Female / Male-to-Female
❑ Transgender Male / Female-to-Male
❑ Non-Binary/Genderqueer
❑Questioning
❑Two Spirit
❑Choose not to disclose
❑Other:_____

Preferred Pronoun:
❑ she/her/hers
❑ he/him/his
❑ they/them/theirs
❑ patient's name
❑ Ze/hir/hirs
❑ ey/em/eirs
❑ xe/xem/xyrs
❑ Decline to answer
❑Unknown
❑Other: _____

EMPLOYMENT STATUS

Employment Status:
❑ Child
❑Full time
❑Part time
❑Not employed
❑On Active Military Duty
❑Retired
❑Seasonal
❑Self-Employed
❑Student Full-Time
❑Student Part-Time
❑Unemployed due to disability
❑Unknown

Veteran/Military Status
❑Active Duty
❑Inactive Duty
❑No previous experience
❑Reservist
❑Uncollected
❑Veteran

Number of Family Members:	**Monthly Income (before taxes) $**

LANGUAGE

What language do you speak at your home:	**Interpreter Needed:** ❑Yes ❑No
❑English ❑Spanish ❑Other: _____	**Preferred:** ❑Male ❑Female ❑No Preference

(turn page over to finish reading and sign this registration form)

RESPONSIBLE PARTY

If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Parent/Legal Guardian Responsible for Bill:	**Birth Date:** / /	**Social Security # of Parent/Legal Guardian:**	
Mailing Address: ❑ Same as above	**City:**	**State:**	**Zip:**
Phone Number:	❑Home ❑Mobile ❑Work		

ADDITIONAL INFORMATION

Homeless Status:

- ❑Not Homeless
- ❑At Risk for Homeless
- ❑Transitional Housing
- ❑Permanent Supportive Housing
- ❑Child at Risk for Homeless
- ❑Living with Others
- ❑Homeless, Unknown Shelter
- ❑Living in Shelter
- ❑Veteran at Risk for Homeless
- ❑Single Occupancy Hotel
- ❑Street, Camp, Bridge
- ❑Currently Not Homeless, Was in the Last 12 Months

Farm Work Recognition: Are you or someone in your household involved in a type of farm work that may include: soil prepping, planting, picking, cleaning, sorting, packing, Christmas tree farming?

❑Yes ❑No

❑ Migrant – You or a member of your household has established a temporary home in order to do farm work
❑ Seasonal – You or a member of your household do farm work that only happens at certain times throughout the year

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

_____ _____

Patient/Guardian signature ***Date***

FOR OFFICE USE ONLY

Initials for Special Confidentiality:_____ Screen By: _____ Total Income: $ _____

TITLE X: Clients pay _____ % per sliding fee scale for non-FPEP covered service.

Address Verification: □ Yes Date/Initials_____ □ Patient declined confidentiality

COMBINED CONSENT FORM

_____ _____

Patient Name ***Patient Date of Birth (DOB)***

TREATMENT AND FINANCIAL

I authorize treatment of the person named above and accept financial responsibility for all treatment, including any necessary or recommended vaccines provided. I authorize Neighborhood Health Center to provide to my insurance companies all information necessary to process insurance claims and assign Neighborhood Health Center all of the insurance benefits due to me to the full extent of my financial obligation. A photocopy or scanned image of this authorization shall be considered as valid as the original.

ACKNOWLEDGMENT OF HIPAA NOTICE

I acknowledge receipt of Neighborhood Health Center's Notice of Privacy Practices.

PATIENT CENTERED PRIMARY CARE HOME CONSENT

Your primary care home will; better coordinate our care to help get you the services you need, listen to your concerns and answer your questions, offer after-hours help and alternatives to the emergency room, help you play an active role in your health. I have read and understand the information on Patient Centered Primary Care Home and consent to be a part of the Neighborhood Health Center Medical Home.

REPRODUCTIVE HEALTH SERVICES

When seeking reproductive health services from Neighborhood Health Center I understand that I am receiving these services voluntarily.

I understand that these services may include:

- Reproductive health counseling on birth control, getting pregnant, healthy pregnancies, and other subjects as needed;
- Providing a birth control method;
- A provider visit for a prescription and maybe a physical exam;
- Testing and/or treatment for sexually transmitted infections (STIs);
- Testing for cervical cancer, pregnancy and/or other health problems; and
- Referrals to other services, if needed.

I understand that all services will be explained and I can ask questions.

I understand I may be given information about birth control methods. I can ask questions and refuse any birth control method I do not want to use.

I understand that I won't be refused care if I owe money from other visits.

(turn page over to finish reading and sign this consent form)

I understand these services do not include 24-hour care, and in case of a medical emergency, I will need to go to an emergency room and pay its costs.

I understand that the services I receive and my medical records are private, except:

- If a judge issues a subpoena for my records. Neighborhood Health Center is required by law to give the records to the court.
- If I have reportable disease, Neighborhood Health Center will be required to report it to Oregon State Public Health.
- The State of Oregon requires all Neighborhood Health Center Staff to report any abuse of vulnerable individuals, which includes children, elders, persons who are mentally ill, developmentally disabled, or living in a long term care facility to The Department of Human Services that is witnessed or learned of inside or outside of a Neighborhood Health Center Clinic.
- I understand I may choose not to talk about sensitive information, such as the age(s) of sex partner(s), and that I will still get services.

I understand that if I get reproductive health services here, I can still apply for or get services from other programs. If I get care from other programs, I can still get services at Neighborhood Health Center.

DENTAL SERVICES

I understand that Neighborhood Health Center partners with different academic institutions and that I may be treated by a student/extern practicing under the direct supervision of a licensed professional at Neighborhood Health Center. I authorize Neighborhood Health Center professionals and their partners to provide such treatment and this authorization shall remain in effect until revoked in writing.

_____ _____

Patient Signature ***Date***

_____ _____

Signature of Patient's Representative *(If patient is under 18)* ***Date***

_____

Relationship of Representative

COMMUNICATION PERMISSIONS FOR PROTECTED HEALTH INFORMATION (PHI)

Patients who are minors (under age 18) may request certain levels of confidentiality and consent to various health care matters depending on their age. Further details regarding this can be provided by NHC staff.

Patient Name:	**Date of Birth:**

IT IS OK FOR NEIGHBORHOOD HEALTH CENTER TO CONTACT YOU? *(please check all that apply)*:

1. Can we send bills to your address? ❑ Yes ❑ No
2. Can we send automated appointment reminders? ❑ Yes ❑ No
   If yes, which type? ❑ Phone call ❑ Text message
3. Can we send you newsletters via email? ❑ Yes ❑ No
4. Can we call you regarding your visit/treatment with us? Types of calls that could be made:
   - Primary Care (lab Results, medical instructions, referrals, medications, etc.) ❑ Yes ❑ No
   - Dental Care ❑ Yes ❑ No
   - Behavioral Health (follow up on concerns, referrals, etc.) ❑ Yes ❑ No
   - Reproductive Health (sexual health, STI treatment, test results) ❑ Yes ❑ No

Preferred Communication: ❑ Do not contact ❑ Mail ❑ Phone ❑Email via MyChart ❑ No preference ❑ Text

WHO MAY WE SPEAK TO REGARDING YOUR HEALTHCARE? *(NOTE: this is not an authorization to release records):*

I authorize Neighborhood Health Center to speak to the following people, in person or by telephone: ❑ Not Applicable

Name: **Relationship:**

Home #: **Work #:** **Mobile #:**

Preferred Language: **Interpreter Needed:** ❑ Yes ❑No

❑ Use this person as an emergency contact ❑ Authorized to sign on behalf of guardian in guardian's absence

Regarding *(please check all that apply)*: ❑ Schedule / cancel appointment ❑ Medical instruction / advice
❑ Prescription drug information ❑ Lab results ❑ Imaging results
❑ **All** information ❑ Other:

Name: **Relationship:**

Home #: **Work #:** **Mobile #:**

Preferred Language: **Interpreter Needed:** ❑ Yes ❑No

❑ Use this person as an emergency contact ❑ Authorized to sign on behalf of guardian in guardian's absence

Regarding *(please check all that apply)*: ❑ Schedule / cancel appointment ❑ Medical instruction / advice
❑ Prescription drug information ❑ Lab results ❑ Imaging results
❑ **All** information ❑ Other:

PLEASE LIST LEGAL REPRESENTATIVE, GUARDIAN, POWER OF ATTORNEY, ETC. IF ANY *(please provide proof)*

Name: _____ ❑ Not Applicable

Relationship: _____ **Phone:** _____

SIGNATURE REQUIRED *(below):*

The authorization may be changed or revoked in writing at any time. It will remain in effect until one (1) year from the date below. By signing below, I acknowledge that this document was given to me in a language that I understand either in writing or as read to me in its entirety.

Signature (Patient/Legal Guardian)	***Date***
Print Name	***Relationship (if not patient)***

SLIDING FEE DISCOUNT PROGRAM

APPLICATION

INSTRUCTIONS

1. In order to received discounted services, all patients must apply annually for the Sliding Fee Discount Program. Eligibility is based on family size and household income, as it relates to current Federal Poverty Guidelines.
2. Please read the *Sliding Fee Discount Program Information* sheet. If you have additional questions, please ask the front desk.
3. Please fill out the application and return it to Neighborhood Health Center (NHC) with proof of income attached. Don't forget to sign and date your application.
4. If you can't attach proof of income to your application today, please return proof of income to NHC within 30 days of submitting this application.
5. List yourself as the first family member, followed by others. For individuals not earning an income (for example, a child within your family), enter zero ($0) for their monthly income.

PERSONAL INFORMATION	
Full Name	
Address	
Phone Number	
Today's Date	

FAMILY MEMBERS

- *Family is defined as a group of two or more people living together who are financially supporting one another.*
- *Report $0 under 'Monthly Income' for any family members who do not support you financially.*

Full Name	**Date of Birth**	**Relationship**	**Monthly Income** *(before taxes)*
		Self	**$**
			$
			$
			$
			$
			$
			$

IF YOU REPORT ZERO FAMILY INCOME OR A SOURCE OF INCOME THAT CANNOT BE PROVED	
How long have you been without a taxable source of income?	☐ > 6 months ☐ 6 months-1 year ☐ 1-2 years ☐ Over 2 years
Why are you unable to provide proof of income?	

ATTESTATIONS	
Please read and initial next to <u>each</u> attestation	
	I attest that I have read the *Sliding Fee Discount Program Information* sheet and understand requirements to participate in the program.
	I understand that discount will not be applied until my application <u>and</u> proof of income are reviewed and accepted by NHC. I understand that if I cannot provide proof of income, discount will not be applied until my request to waive proof of income is reviewed and approved by NHC's Chief Operating Officer or their designee.
	I understand that eligibility in the program is valid one year from the date my application is approved. I understand I must reapply each year to remain in the program.
	I understand that should my income or family size change during my one-year period of eligibility, I will report changes to NHC and reapply for the program.
	I understand that should my insurance prohibit a waiver of my co-pay, the full co-pay will be collected at the time of service. If you are unsure, contact your insurance company.

SIGNATURE	
I certify that the information stated is true and accurate by signing this form. If false information is used to obtain assistance, I will be removed from the sliding fee discount program.	
Applicant Signature	**Date**

---------- ***DO NOT WRITE BELOW THIS LINE*** ----------

OFFICE USE ONLY

Applicant/s Information	
Patient/s MRN	
Monthly Family Income (from table on pg.1)	**$**
Family Size (from table on pg.1)	
Proof of Income Status at Time of Application	☐ A. Yes, proof attached ☐ B. Pending, 30-day grace period ☐ C. No, applicant has listed zero or cash source of income, pending approval by COO or designee
Date	
Reviewed By	

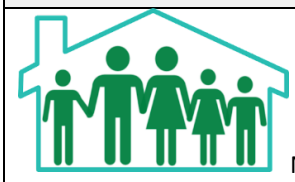
Proof of Income Status: A or B	
Monthly Family Income (verified by proof)	**$**
Discount Class	☐ A ☐ B ☐ C ☐ D ☐ E
Date Verified	
Reviewed By	
Proof of Income Status: C	
Decision	☐ Approved ☐ Denied
Discount Class	☐ A ☐ B ☐ C ☐ D ☐ E
Date of Review	
Signature of COO or Designee	

SLIDING FEE DISCOUNT PROGRAM INFORMATION

WHY SHOULD I SIGN UP FOR THE PROGRAM?

Neighborhood Health Center (NHC) offers discounted services to patients living at or below 200% of the most current Federal Poverty Guidelines (FPG). Eligibility to participate in the program is based only on the patient's household income and family size, as it relates to FPGs. All patients are encouraged to apply, including patients with insurance. Discounts apply to all NHC services provided directly at NHC clinics and those offered in referral. Discounts vary depending on the patient's assigned discount pay class (see Discount Classes A-D in the Monthly Income table below) and the service being used by the patient at the time of appointment (i.e. medical, dental, or behavioral health). Please take a moment to review this information sheet prior to filling out your application. If you have questions, please ask an NHC staff member for assistance.

WHO SHOULD I INCLUDE IN MY FAMILY SIZE?



NHC defines a family as a group of two or more people living together who are financially supporting one another.

Do NOT include:

- Family members who do not live with you
- Family members who are financially independent

Still not sure who to include? Ask us!

WHAT IS ACCEPTABLE PROOF OF INCOME?

For each member contributing income to the family, attach at least one of the following documents to your application:

- ✓ Two (2) weeks of most recent pay stubs
- ✓ Check stubs from Unemployment Insurance
- ✓ Previous year W-2
- ✓ Previous year completed tax return
- ✓ Government-issued documentation for other non-wage income such as Social Security, Worker's Comp, Cash Assistance, Child Support, Alimony, Veteran's Benefits, Retirement, or Pension
- ✓ Previous three (3) months of bank statements
- ✓ Letter from employer
- ✓ If self-employed: prior year tax return or most recent three (3) months of bank statements

WHAT DISCOUNT WILL I RECEIVE?

Below is a table displaying the 2022 Federal Poverty Guidelines (FPG). Only patients reporting a family income at or below 200% of FPG will qualify. Columns A through D are eligible for discounted services. Column E (above 200% FPG) must pay in full for charges and will not receive a discount. If you fall within Column E, you are not eligible to participate in the program.

MONTHLY INCOME											
Discount Class		**A**		**B**		**C**		**D**		**E**	
FPG		**0-100%**		**>100-133%**		**>133-166%**		**>166-200%**		**>200%**	
Family Size	1	$0	$1,133	$1,134	$1,506	$1,507	$1,880	$1,881	$2,265	$2,266	& Up
	2	$0	$1,526	$1,527	$2,029	$2,030	$2,533	$2,534	$3,052	$3,053	& Up
	3	$0	$1,919	$1,920	$2,552	$2,553	$3,186	$3,187	$3,838	$3,839	& Up
	4	$0	$2,313	$2,314	$3,076	$3,077	$3,839	$3,840	$4,625	$4,626	& Up
	5	$0	$2,706	$2,707	$3,599	$3,600	$4,492	$4,493	$5,412	$5,413	& Up
	6	$0	$3,099	$3,100	$4,122	$4,123	$5,145	$5,146	$6,198	$6,199	& Up
	7	$0	$3,493	$3,494	$4,645	$4,646	$5,798	$5,799	$6,985	$6,986	& Up
	8	$0	$3,886	$3,887	$5,168	$5,169	$6,450	$6,451	$7,772	$7,773	& Up
	9	$0	$4,279	$4,280	$5,691	$5,692	$7,103	$7,104	$8,558	$8,559	& Up
	10	$0	$4,673	$4,674	$6,214	$6,215	$7,756	$7,757	$9,345	$9,346	& Up

FPG: Federal Poverty Guidelines, published by HHS, effective 1/12/2022
For families/households with more than 10 persons, add $393 for each additional person

EXAMPLE 1

Susan is a single mother of two young children, Susan also cares for her mother, who lives with her and her children. Susan's family size is 4. Susan is the only person in her family earning income. Susan earns $2,600 per month in income. Susan belongs to Discount Class B.

EXAMPLE 2

Jose is married to his wife Miranda. They have three young children who live with them. Jose earns $2,300 per month at his job. Jose's wife earns $2,700 per month. Together, the couple earns $5,000 per month. Jose's family size is 5. Jose belongs to Discount Class D.

WHAT AM I RESPONSIBLE TO PAY?

Once you figure out what Discount Class you belong to (A-D), discounts vary depending on the service you are using at the time of your service. Services are broken into groups and include medical, dental, and behavioral health.

Discounts apply to clinical services. Note that dental and pharmacy supplies and equipment have separate discounts because they are not clinical services.

	A	B	C	D	E
Medical & Clinical Pharmacy Services	$25	$35	$40	$45	100% of Full Charges
Dental Services*	$25	50% of Full Charges	60% of Full Charges	70% of Full Charges	100% of Full Charges
Dental Supplies & Equipment*	50% of Full Charges	50% of Full Charges	60% of Full Charges	70% of Full Charges	100% of Full Charges
Behavioral Health & Psychiatry Services	$5	$10	$15	$20	100% of Full Charges
Pharmacy Dispensed Prescription Fees**	$5 Dispensing Fee + Discounted Medication Cost	$8 Dispensing Fee + Discounted Medication Cost	$10 Dispensing Fee + Discounted Medication Cost	$12 Dispensing Fee + Discounted Medication Cost	100% of Full Charges

**$25 payment expected at the time of service.*
***Ask your Pharmacist for a quote on your medications. Call 503-941-3160 for more information.*

EXAMPLE 1

I belong to Discount Class B. I came in today for a medical visit with my Doctor. I am responsible to pay $35 for my visit. The remainder of my charges will be adjusted by NHC so that $35 is my only responsibility.

EXAMPLE 2

I belong to Discount Class C. I came in today for a dental exam and cleaning. The total of these charges was $300. I am responsible to pay 60% of these charges. The remainder of my charges will be adjusted by NHC so that $180 is my only responsibility ($180 = 60% of $300 charges).

EXAMPLE 3

I belong to Discount Class A. I came in today for an appointment to discuss my diabetes with a behaviorist. I am responsible to pay $5 for my visit. The remainder of my charges will be adjusted by NHC so that $5 is my only responsibility.

EXAMPLE 4

I belong to Discount Class D. I am diabetic and NHC is going to deliver my insulin medication to my home. My pharmacist told me I will pay a total of $16 for my insulin. This includes the cost for the medication plus the dispensing fee.

NEIGHBORHOOD HEALTH CENTER

I NEED MORE INFORMATION

Not sure who to include in your family size? Not sure what to bring to prove your income? Not sure what discount class you will qualify for? Not sure what you will be charged for a specific service?

Ask the front desk staff at your NHC clinic to answer any additional questions you have.

Patient Name: _____ **Date of Birth**: _____

DENTAL HISTORY

1. Is this your first visit to a dentist? ..... YES NO
2. Do you have dental pain, bleeding gums or sensitive teeth? ..... YES NO
3. Have you ever had an injury to your face or jaw, or do you have jaw pain? ..... YES NO
4. Have you ever had any problems associated with dental treatment..... YES NO
5. Do you brush and floss your teeth and mouth daily? ..... YES NO
6. Do you currently, or have you ever used tobacco products? ..... YES NO
   If yes, explain _____
7. Do you use fluoride tablets or rinses? ..... YES NO
8. What type of dental treatment do you feel you need? _____

MEDICAL HISTORY

The following information is necessary for you to receive dental treatment and will be completely confidential. Dental treatment will not be refused because of existing medical conditions.

1. Are you receiving any type of medical treatment or have you been hospitalized? ..... YES NO
2. Have you had a recent illness or surgery? ..... YES NO
3. Are you taking any prescription, non-prescription or herbal medications? ..... YES NO
   If yes, list them _____
   _____
4. Are you allergic to any medications or to latex? ..... YES NO
   If yes, list them _____
5. Have you ever had excessive bleeding requiring medical treatment? ..... YES NO
6. If female, are you pregnant? YES NO. If yes, when are you due? _____
7. List your medical provider's name and phone number _____

8. Indicate which of the following you have had or have at present. Please circle.

Alcoholism	Clotting Disorder	Heart murmur/Prosthetic Heart Valve	Osteoporosis/Bisphosphonate Drugs
Allergies	Congenital Heart Defect	Heart Endocarditis	Pacemaker
Anemia	Diabetes	History of blood transfusion	Seizures
Anxiety	Drug Addiction	HIV/AIDS	Sickle cell anemia
Arthritis/Joint disorder	Emphysema/COPD	Hypertension	Sinus problems
Asthma	ED Drug Therapy	Kidney Disease	STD
Autism	Fainting/Dizziness	Liver Disease/Hepatitis	Stomach ulcers
Broken Jaw	Glaucoma/Cataracts	Mental Health Disorder	Stroke
Cancer	Heart Disease/Surgery	Myocardial infarction (Heart attack)	Thyroid disease
Chest Pain/Angina	Heart Failure	Organ Transplant	Tuberculosis

9. Do you have any disease, condition or problem not listed above? YES NO Explain: _____

I certify that the information given is complete and correct. Any necessary treatment is hereby authorized.

Patient or Legal Guardian Signature _____ **Date** _____