PEDIATRIC PATIENT REGISTRATION FORM

Today's Date: _____ **Form Type:** ☐ New Patient ☐ Annual Update

PATIENT INFORMATION

Legal Last Name:	**Legal First Name:**	**Legal Middle Name:**	**Preferred First Name:**

Previous Full Name (if applicable):	**Birth Date:** / /	**Age:**	**Social Security #:**

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

For Patient 12 Years or Older . . .	**Patient Cell Phone:** ☐ N/A	**Patient E-mail Address:** ☐ N/A

Parent/Legal Guardian Name:	**Cell Phone:**	**E-mail Address:**

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

Best way to contact for results, follow up, or scheduling? (check all that apply)
☐ Parent/Guardian Cell Phone ☐ Parent/Guardian E-mail ☐ Patient Cell Phone ☐ Patient E-mail

Race:
☐ Alaskan Native ☐ American Indian ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Samoan ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Other Asian ☐ Black/African American ☐ White ☐ Unknown ☐ Refuse to disclose

Ethnicity:
☐ Mexican, Mexican American, or Chicano/a
☐ Another Hispanic, Latino/a, or Spanish Origin
☐ Multiple Hispanic, Latino/a, or Spanish Origin
☐ Non-Hispanic or Latino/a
☐ Cuban ☐ Puerto Rican
☐ Unknown ☐ Refuse to disclose

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

Gender Identity:
☐ Female ☐ Questioning ☐ Male ☐ Two Spirit ☐ Transgender Female ☐ Refuse to disclose ☐ Transgender Male ☐ Non-Binary / Genderqueer ☐ Other: _____

Preferred Pronouns:
☐ she / her / hers ☐ ey / em / eirs ☐ he / him / his ☐ ve / vir / vis ☐ they / them / theirs ☐ xe / xem / xyrs ☐ patient's name ☐ Refuse to disclose ☐ ze / hir / hirs ☐ Unknown ☐ Other: _____

EMPLOYMENT STATUS OF PARENT / GUARDIAN

Employment Status of Parent/Guardian:
☐ Full time ☐ Part time ☐ Seasonal ☐ Retired ☐ Self-employed ☐ Not employed ☐ Unemployed due to disability ☐ Student Full-Time ☐ Student Part-Time ☐ On Active Military duty

Veteran/Military Status of Parent/Guardian:
☐ No previous experience ☐ Active Duty ☐ Inactive Duty ☐ Reservist ☐ Veteran ☐ Separated / Combat Veteran

Is the patient a dependent of a current or former employee of our company? ☐ Yes ☐ No

INSURANCE

If the patient is uninsured or has Medicaid, please complete *Primary Insurance Type* and skip the remaining questions. If the patient has Medicare or Private insurance, fill in the details below.

Primary Insurance Type: ☐ Uninsured ☐ Medicaid ☐ Medicare ☐ Private / Other

Insurance Company Name:	**Insurance ID #:**

Subscriber Name:	**Subscriber Date of Birth:** / /

Secondary Insurance Company Name:	**Secondary Insurance ID #:**

PEDIATRIC PATIENT REGISTRATION FORM

HOUSEHOLD INCOME

Collecting this information allows us to offer you discounted services. If you do not know your monthly income, ask us for help.

Number of Household Members (include yourself):	**Monthly Household Income (estimated):**
	$

FINANCIALLY RESPONSIBLE PARTY

Individual listed on the patient's account for billing purposes.

Parent/Legal Guardian Responsible for Bill:	**Birth Date:** / /	**Social Security #:**	
Mailing Address:	**City:**	**State:**	**Zip Code:**

Phone Number: ☐ Home ☐ Mobile ☐ Work

LANGUAGE

What language do you *speak* at home:
☐ English ☐ Spanish ☐ Other: _____

Interpreter Needed: ☐ Yes ☐ No
If Yes: ☐ Male ☐ Female ☐ No Preference

What language do you *write* at home: ☐ English ☐ Spanish ☐ Other: _____

ADDITIONAL INFORMATION

We are a community health center with a mission to serve all regardless of ability to pay or lack of insurance, including individuals and families experiencing homelessness or those employed in agricultural activities.

Homelessness Status of Patient:

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

Agricultural Workers: In the last 2 years, have you or another member of your household worked in any type of agriculture (farm work) that may include: soil prepping, planting, picking, cleaning, sorting, packing, transporting, or work with livestock, etc.?

☐ Yes ☐ No (if no, do not answer the two questions below)

☐ *Migrant* – In the last 2 years, you or a member of your household has lived away from home in order to work in any type of agriculture (farm work). OR in the last 2 years, have you or a member of your household stopped migrating to work in agriculture (farm work) because of a disability or age (too old to work)?

☐ *Seasonal* – In the last 2 years, you or a member of your household do farm work that only happens at certain times throughout the year.

SIGNATURE & AUTHORIZATION

I authorize Neighborhood Health Center (NHC) to furnish information regarding the patient's medical history, diagnosis, and treatment to their insurance company regarding claims for benefits. If said insurer fails to meet this obligation or if the patient is non-insured, I agree to be responsible for any fees related to treatment of the above-named patient. I acknowledge I have been provided NHC's Notice of Privacy Practices which explains how information may be used and/or shared as required/permitted by law. I acknowledge that I have been provided with, and will adhere to, NHC's Patient Rights and Responsibilities as the primary caretaker of the patient. On behalf of the named patient, I hereby consent to treatment by NHC professional staff and/or students under direct supervision of licensed NHC clinicians, either at a NHC clinic or via telehealth (i.e., audio and/or video encounter). I understand services will be delivered to the patient in their preferred language of understanding and that this consent to treatment is effective 12 months beyond the date of signature. On behalf of the patient, I hereby give my consent for treatment by NHC and understand that I may cancel this consent at any time, in writing.

_____

Printed Name of Patient or Parent / Guardian

_____ _____

Signature of Patient or Parent / Guardian ***Date***

DENTAL HEALTH HISTORY

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 an adverse reaction to materials, medications, or anesthetic used during a dental visit? ☐ 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, alcohol, or recreational drugs? ☐ Yes ☐ No
   If yes, please 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. What is your height and weight? Height: ____ ft ____ in Weight: _____ lbs
8. Indicate which of the following you have had or have at present. Please check the box.

☐ Alcoholism	☐ Clotting Disorder	☐ Heart Murmur/Prosthetic Heart Valve/Endocarditis	☐ Pacemaker
☐ Allergies	☐ Congenital Heart Defect	☐ History of Blood Transfusion	☐ Seizures
☐ Anemia	☐ Diabetes	☐ HIV/AIDS	☐ Sickle Cell Anemia
☐ Anxiety	☐ Drug Addiction	☐ Hypertension	☐ Sinus Problems
☐ Arthritis/Joint Disorder	☐ Emphysema/COPD	☐ Kidney Disease	☐ Sexually Transmitted Infection
☐ Asthma	☐ ED Drug Therapy	☐ Liver Disease/Hepatitis	☐ Stomach Ulcers
☐ Autism	☐ Fainting/Dizziness	☐ Mental Health Disorder	☐ Stroke
☐ Broken Jaw	☐ Glaucoma/Cataracts	☐ Myocardial Infarction (Heart Attack)	☐ Thyroid Disease
☐ Cancer	☐ Heart Disease/Surgery	☐ Organ Transplant	☐ Tuberculosis
☐ Chest Pain/Angina	☐ Heart Failure	☐ Osteoporosis / Bisphosphonate Drugs	☐ None of the Above

9. Do you have any disease, condition, or problem not listed above? ☐ Yes ☐ No
   If yes, please explain: _____

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

Patient or Legal Guardian Signature _____ Date _____

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.

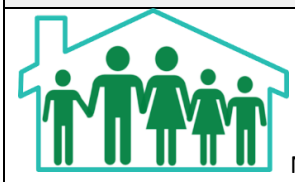
Signature (Patient/Legal Guardian)	***Date***
Print Name	***Relationship (if not patient)***

SLIDING FEE DISCOUNT PROGRAM 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 2023 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	$1,215	$1,216	$1,616	$1,617	$2,017	$2,018	$2,430	$2,431	& Up
	2	$0	$1,643	$1,644	$2,186	$2,187	$2,728	$2,729	$3,287	$3,288	& Up
	3	$0	$2,072	$2,073	$2,755	$2,756	$3,439	$3,440	$4,143	$4,144	& Up
	4	$0	$2,500	$2,501	$3,325	$3,326	$4,150	$4,151	$5,000	$5,001	& Up
	5	$0	$2,928	$2,929	$3,895	$3,896	$4,861	$4,862	$5,857	$5,858	& Up
	6	$0	$3,357	$3,358	$4,464	$4,465	$5,572	$5,573	$6,713	$6,714	& Up
	7	$0	$3,785	$3,786	$5,034	$5,035	$6,283	$6,284	$7,570	$7,571	& Up
	8	$0	$4,213	$4,214	$5,604	$5,605	$6,994	$6,995	$8,427	$8,428	& Up
	9	$0	$4,642	$4,643	$6,173	$6,174	$7,705	$7,706	$9,283	$9,284	& Up
	10	$0	$5,070	$5,071	$6,743	$6,744	$8,416	$8,417	$10,140	$10,141	& Up

FPG: Federal Poverty Guidelines, published by HHS, effective 1/19/2023
For families/households with more than 10 persons, add $428 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 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.

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	