PATIENT REGISTRATION FORM

Section I — Demographic Information

Legal First Name	MI	Last	Preferred Name	Social Security #
				_____-____-_____

Birth Sex	Gender Identity (18+)	Sexual Orientation (18+)	DOB
□ Female □ Male	□ Male □ Female □ Decline □ Other □ Transgender Male (FtoM) □ Transgender Female (MtoF) □ Neither Exclusively Male or Female	□Straight □Gay □Other □Bisexual □Lesbian □Decline	____/_____/_____

Marital Status	Race
□ Single □ Divorced □ Legally Separated □ Married □ Widow □ Unknown	□ Caucasian □ Black/African American □ Asian □ American Indian or Alaska Native □ Native Hawaiian or Pacific Islander □ Other Race:Specify_____

Ethnicity	Primary Language Spoken	Employment Status
□Latino/Hispanic □Non-Latino/Hispanic □Not Reported	□English □Spanish □ Sign Language □ Other:Specify_____	□Employed □Unemployed □Self □Student □Disabled □Retired

Veteran	Seasonal or Migrant Worker	Current Living Arrangement
□ Yes □ No	□ Seasonal □ Migrant □ No	□ Not Homeless □Homeless Shelter □ Doubled Up □ Transitional □ Street □ Other

Mailing Address	Zip Code

Email Address	Home Phone	Work Phone
	( )	( )

Mobile Phone	Preferred Phone #	Preferred Appt. Reminder Method
( )	□ Home □ Mobile	□ Voice □E-Mail □ Text □ No Contact

Referral Source	PCP (If Not SCMC)
□ SCMC Employee □ Outside Provider □ Friend □ Walk In □ Internet □ Other:_____	

Section II — Guarantor (Financial Responsible Individual)

□ **PATIENT IS GUARANTOR** (No need to complete remainder of	□ Person □ Company
□ Child □ Spouse □ Parent □ Self □ Employee □ Special Dependent □ Grandchild □ Other □ Aunt/Uncle □ Niece/Nephew	
Patient's Relation to Guarantor	**Guarantor's Social Security Number**

Guarantor's Legal First Name	Middle	Last

Birth Sex	DOB	Marital Status	Primary Language Spoken
□ Female □ Male	____/_____/_____	□ Single □ Divorced □ Legally Separated □ Married □ Widow □ Unknown	□English □Spanish □ Sign Language □Other:Specify_____

Address	Zip Code

Email Address	Home Phone	Work Phone
	( )	( )

Insurance Information

PRIMARY INSURANCE	SECONDARY INSURANCE
Type: □Medicare □Medicaid □Private □None	Type: □Medicare □Medicaid □Private □None
Plan Name:	Plan Name:
Subscriber's Name	**Subscriber's Name**
Subscriber's Address	**Subscriber's Address**
Subscriber Zip Code / **Subscriber Date of Birth**	**Subscriber Zip Code** / **Subscriber Date of Birth**
Subscriber's SSN / □ Male □ Female **Subscriber's Gender**	**Subscriber's SSN** / □ Male □ Female **Subscriber's Gender**
Group Number	**Group Number**
Policy Number / **Copay**	**Policy Number** / **Copay**
Subscriber's Relation to Patient	**Subscriber's Relation to Patient**

PHARMACY INFORMATION

PRIMARY PHARMACY	SECONDARY PHARMACY
Pharmacy Name	**Pharmacy Name**
Pharmacy City / **Pharmacy State**	**Pharmacy City** / **Pharmacy State**

Do you have any problems with: □ Vision □ Hearing □ Reading □ Speaking

IN CASE OF EMERGENCY

Name of Contact	Relationship to Patient	( ) Phone Number

I,_____, give my permission to release any health information to the following:

Name	Phone Number

Name	Phone Number

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

Patient/Guardian Signature **Date**

Consent for Treatment/Services

I hereby apply for care under this program based on the information give and permit the personnel of South Central Medical Center to verify any of the information I have furnished.

_____
Initials

I understand that demographic (age, sex, rage, income, etc.) information about me and/or my family and information about the number of services that I/we receive may be used without my name or other information that would individually identify me. This information will assist South Central Medical Center in its efforts to obtain services that will help me or my family.

_____
Initials

I hereby authorize the staff and personnel of South Central Medical Center to perform such diagnosis procedures and other medical procedures as they may deem necessary or advisable from time to time.

_____
Initials

I hereby authorize South Central Medical Center to release any appropriate medical information to any hospital to which I/my family may need to be admitted and/or as allowed under the SCMC Notices of Privacy Practices

_____
Initials

I further understand that if I have failed to give correct and complete information regarding the questions I have been asked, I/my family as listed is subject to 100% payment billing and subsequently standard collection procedures for any delinquent accounts regardless of payment

_____
Initials

I understand that I am responsible for the payment for all services received at South Central Medical Center that are not paid for by any other source.

_____
Initials

Patient/Guardian Signature	**Date**

ABOUT OUR NOTICE OF PRIVACY PRACTICES

We are committed to protecting your personal health information in compliance with the law. SCMC's Notice of Privacy Practices states:

1. our obligation under the law with respect to your personal health information.
2. how we may use and disclose the health information we keep about you.
3. your rights relating to your personal health information.
4. our rights to change our Notice of Privacy Practices.
5. how to file a complaint if you believe your privacy rights have been violated.
6. the conditions that apply to uses and disclosures not described in this notice.
7. the person to contact for further information regarding our privacy practices.

We are required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

I, _____, hereby acknowledge that I have been offered/received a copy of the Notice of Privacy Practices.

Patient/Guardian Signature	**Date**

Medical Home Agreement with South Central Medical Center

This Medical Home Agreement is an AGREEMENT between YOU and YOUR Community Health Center PROVIDER, to focus on meeting ALL of your healthcare NEEDS.

The principles of the Medical Home with South Central Medical Center are as follows:

Personal Physician/Provider- each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician/Provider Directed Medical Practice- the personal physician leads a team of individuals at the practice level who collective take a responsibility for the ongoing care of patients.

Whole Person Orientation- the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, acute care, chronic care, preventative services; and end of life care.

Quality and safety- are the hallmarks of care at South Central Medical Center

Enhanced access to care- South Central Medical and Resource Center is available through systems such as open scheduling and expanded hours to provide you with the best care.

As a SCMC patient, there are rules you must follow. It is your responsibility to SCMRC to:

Be aware of SCMRC's office hours so you know when you can be seen.

Monday through Thursday: 8 a.m. to 5 p.m.
Friday: 7 am to 8:45 am (walk in urgent care appointments, no appointment necessary) 9 am to 1 pm regular appointment scheduling

Call for an appointment as early as possible and keep the appointments you make.

You may have to wait up to two (2) weeks to be seen for checkups and shots.

Even if you have an appointment, you may have to wait past that time to see your provider, you should ask to reschedule if you cannot wait.

If you cannot keep your appointments, you must call the provider at least 24 hours in advance to cancel or reschedule your appointment. SCMRC reserves the right to dismiss you as a patient if you continually miss your appointments.

You must reschedule your appointment for another time if you will be more than 15 minutes late for any scheduled appointments, even if you call in advance to say you will be late

When you call SCMC you should always:

Tell the staff why you need an appointment. Please inform the staff if this is an acute situation that needs to be addressed within 24 hours

Have you medical insurance information available, if applicable.

Call SCMRC if your problem gets worse before you scheduled visit. Ask to speak to our triage nurse and tell them your symptoms, they can recommend if you need to be seen sooner than your scheduled appointment.

During your SCMC visit you should always:

Give the staff information they need to help you. This includes telling them about all of your symptoms.

Tell the staff and providers ALL of your medical history.

Inform SCMC of ALL prescription drugs, over the counter medications and herbal supplements you are using.

Inform SCMC of any other health care appointments you have so they can follow up with those providers.

Follow the treatment plans and guidelines that your provider gives you. SCMC providers practice evidence based care which includes the patient's participating in their healthcare options, treatments and referrals. All patients are asked to participate in the coordination of self care management goals and participate in health education activities as recommended by their provider.

After Hours Coverage:

SCMRC has an after hour's nurse line available for all patients anytime our office is not available by calling (405) 756-1414 to reach the after hours service. The nurses will provide you advice on how to handle your medical situation if SCMC is not available and will contact your physician if they feel necessary to have you receive specific instructions from your provider.

If you think you are having a true *medical* emergency, go to the nearest emergency room or call 911

As a patient of SCMC you should expect the providers and staff to treat you professionally and respectfully. It is also expected that you and your family members treat the providers and staff respectfully and refrain from using rude, offensive, or threatening behavior. You may call Dana Ramming, Chief Executive Officer, at 405-756-1414 to report any complaints or concerns regarding providers and staff.

I select:

- □ Sean Baker APRN
- □ Elizabeth "Liz" Clowers APRN

as my personal provider at SCMC. I understand this provider will be my primary contact for my medical care at SCMC, however I understand that in an acute situation I could be scheduled to see any available member of the medical team to ensure that all of my needs are met. I understand that SCMC strives to schedule every patient with their personal clinician but due to vacations, seasonal events and/or unforeseen events, you may have to be seen by another providers at SCMC.

South Central Medical and Resource Center is committed to providing the highest quality of care to all of our patients. In order to provide you with the highest quality of care it is important that we are informed of any other health care providers who provide you care. Please complete the following form as completely as you can:

Provider Name	**Phone Number**	**Specialty**
Provider Name	**Phone Number**	**Specialty**
Provider Name	**Phone Number**	**Specialty**
Provider Name	**Phone Number**	**Specialty**
Provider Name	**Phone Number**	**Specialty**

Patient's Printed Name

Patient/Guardian Signature **Date**

Family Income Sliding Fee Information

Total Estimated Annual Income Household Income

REQUIRED:

Number in Household	At least-BUT not more than	At least-BUT not more than	At least-BUT not more than	At least-BUT not more than	At least-BUT not more than
1	$14,580 & Below	$14,581 to $21,870	$21,871 to $25,515	$25,516 to $29,160	$29,161 & Above
2	$19,720 & Below	$19,721 to $29,580	$29,581 to $34,510	$34,511 to $39,440	$39,441 & Above
3	$24,860 & Below	$24,861 to $37,290	$37,291 to $43,505	$43,506 to $49,720	$49,721 & Above
4	$30,000 & Below	$30,001 to $45,000	$45,001 to $52,500	$52,501to $60,000	$60,001 & Above
5	$35,140 & Below	$35,141 to $52,710	$52,711 to $61,495	$61,496 to $70,280	$70,281 & Above
6	$40,280 & Below	$40,281 to $60,420	$60,421 to $70,490	$70,491 to $80,560	$80,561 & Above
7	$45,420 & Below	$45,421 to $68,130	$68,131 to $79,485	$79,486 to $90,840	$90,841 & Above
8	$50,560 & Below	$50,561 to $75,840	$75,841 to $88,480	$88,481 to $101,120	$101,121 & Above

1. Match the number of people living at home with the "number in household" above.
2. Move across the scale until your estimated yearly income corresponds with the income category.
3. Circle the appropriate box. You may indicate your desire to refuse to give this information by checking the box below and signing.

By signing below, I acknowledge that this is the best estimate of my total household income.

□ Please check if you are invoking your right to refuse the estimate of your total annual household income.

/ /

Signature **Print Full Name** **Date**

OPTIONAL:

South Central Medical Center offers patient **WITH** and **WITHOUT** insurance a discount on their medical bills if they qualify for our sliding fee scale. The discount percentage is based on the NET income of ALL members of the household and the number of family members. If you wish to apply for this discount we need income verification. **Income must be verified with copies of paystubs, income tax returns, award letters or other applicable forms of income verification.** By providing additional information along with the proof of income our staff will determine your eligibility for sliding fee scale discount. Please fill out information below.

Please list all household members including yourself.

Name	Date of Birth

Name	Date of Birth