JOHNSON HEALTH CENTER

REGISTRO del PACIENTE

Información del paciente

Nombre: _____ Inicial _____ Apellido: _____

Direccción: _____

Ciudad: _____ Estado: _____ Zip: _____

Fecha de nacimiento: _____

Identificar quien llena esta forma(haga un circulo): Si mismo/Paciente Padre/Guardián (nombre):_____

Información de contacto *(si el paciente es menor, usa información del contacto del padre/guardián legal.)*

Email: _____

Teléfono de casa: _____ Celular: _____ teléfono del trabajo: _____

Haga un círculo por abajo con la información del paciente, no con la del padre/guardián legal, si el paciente es menor.

Estado civil:	Soltero/a	Casado/a	Divorciado/a	Viudo/a			
Orientación Sexual:	Heterosexual	Homosexual	Bisexual	Otra cosa	No sé	No quiero divulgar	
Genio:	Masculino	Femenino	Trans-sexual hombre-a-mujer	Trans sexual, mujer-a-hombre	Otro	No quiero divulgar	
Lengua Preferida:	Inglés	Español	Coreana	Otro			
Origen Etnico:	Hispano/a	No Hispano/a					
Raza:	Nego/ Afrioamericano	Blanco	Hawaian	Otro polinesio	Nativo noretamericano/nativo de Alaska	Asiatico	Más de una sola raza
Empleado:	Jornada completa	Media Jornada	Autonomo	Sin empleo	Retirado	Militar activo	
¿Es Vd. un estudiante?	Sí	No		**¿Es Vd. un veterano?**	Sí	No	
Seguro:	Medicaid	Medicare/ Medicaid QMB	Seguro Privado	No tengo seguro	No tengo seguro para los medicamentos		

¿Cómo se enteró? (haga un cheque):

- ☐ Una experiencia anterior con Johnson Health Center
- ☐ Una Referencia (Free Clinic, Social Services, etc.)
- ☐ Por palabra de boca (amistad, familiar)
- ☐ Internet (Facebook, website)
- ☐ Festival (evento de salud, feria artesanal, etc.)
- ☐ Periódico (notica del día, aviso)
- ☐ Televisor

El Garante/La persona Responsable *(si es distincta la información del paciente arriba)*

Nombre: _____ M.I.: _____ Apellido: _____

Dirección: _____

Ciudad: _____ Estado: _____ Zip: _____

Fecha de nacimiento: _____ Relación al paciente: _____

Email: _____

Teléfono de casa: _____ Celular: _____ Teléfono del trabajo: _____

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AUTHORIZATION FOR TREATMENT

_____ *Initials*

_____ *Date*

I consent for Johnson Health Center's appropriate personnel and/or clinical staff to perform acute, chronic, and/or emergency medical treatment and preventative, health maintenance, and/or behavioral/mental health care as deemed medically necessary. (If the named individual on other side of this page is a minor at the time of consent, a parent or legal guardian must sign this consent for treatment). A "Behavioral Health Consultant" is a member of the primary care team that works closely with your medical provider to recognize and address medical conditions associated with acute and chronic mental and emotional disordered conditions. There is only one electronic health record used between primary care team members in addressing your treatment plan of care and this health information is shared between these primary care team members.

AUTHORIZATION FOR PAYMENT

_____ *Initials*

_____ *Date*

I authorize the release of any and all medical information necessary to process my insurance claims. I permit a copy of the authorization to be used in place of the original. I authorize Johnson Health Center to file my insurance for services rendered. I request that payment be made directly to Johnson Health Center. I certify that the information that I have reported with regard to my insurance coverage and my personal information is correct. I understand that claims may be filed electronically through a safety net Internet portal. I understand that I am responsible for any and all balances that my insurance company does not pay.

AUTHORIZATION TO LEAVE MESSAGES

_____ *Initials*

_____ *Date*

If we are unable to contact you and you have an answering machine or voicemail, do we have your permission to leave a message containing medical information (circle appropriate): **YES NO**

If yes, where may we leave messages (circle appropriate): **HOME CELL WORK**

NOTICE OF PRIVACY PRACTICES

_____ *Initials*

_____ *Date*

I have received and read the Notice of Privacy Practices from Johnson Health Center.

PATIENT RIGHTS &RESPONSIBILITIES

_____ *Initials*

_____ *Date*

I have received a copy of the Patient Rights & Responsibilities and had an opportunity to ask question regarding them.

MEDICATION POLICY

_____ *Initials*

_____ *Date*

I understand that Johnson Health Center will access the Virginia Prescription Monitoring Program to verify medication use and to avoid medication interactions.

_____ Date: _____

Patient Signature (Parent/Guardian if minor)

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(This consent form will be used as needed and you may revoke or change any of the above consents at any time)

Members of the Household

You must list ALL members of the household, including yourself. This includes age, relationship to applicant, type of insurance, and ALL sources of income. (Wages, child support, disability, social security, SNAP, etc.)

Name	Age	Relationship	Income	Type of Insurance

Household Income

Place of Employment: _____

If you are unemployed, how long? _____

How many hours per week do you work on average? _____

What is your rate of pay? _____

Pay period: ☐ Bi Weekly ☐ Twice Monthly ☐ Monthly ☐ Weekly

Does anyone in the household receive Disability, Social Security, or Pension income? (Please circle):

Yes No

If there is more than one person receiving any of these benefits, please specify _____

Amount: Disability_____Social Security _____Pension _____

Primary Medical Insurance Information

Insurance: _____ Name of insured: _____

Insured's D.O.B.: _____ Relationship to patient: _____

Group number: _____ Policy number: _____ Effective date: _____

Secondary Medical Insurance Information

Insurance: _____ Name of insured: _____

Insured's D.O.B.: _____ Relationship to patient: _____

Group number: _____ Policy number: _____ Effective date: _____

Spouse or Emergency Contact Information

Full name: _____

Address: _____

City: _____ State: _____ Zip: _____

(Phones) Home: _____ Cell: _____ Work: _____

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What is JHC Reduced Fee?

As a Federally Qualified Health Center, Johnson Health Center does not discriminate based upon a patient's ability to pay. JHC offers to all patients the opportunity to apply for the Reduced Fee program.

Reduced Fee eligibility is determined using family size, household income, and the Federal Poverty Guidelines as updated annually by the Department of Health and Human Services. Federal Poverty Levels are determined annually as part of the Federal Poverty Guidelines.

Reduced Fee Release of Information

I, the undersigned, attest to the accuracy and truth of the information provided within this application for services. Johnson Health Center staff may verify all information provided.

I authorize the release of information to Johnson Health Center Medication Assistance Program and the sharing of information about my application to other agencies, pharmaceutical companies, and physicians.

I understand that any changes in income and household must be reported to the Reduced Fee Coordinator as soon as possible. I will also report changes in address and phone number.

I understand that it is my responsibility to provide documentation and update my application every year or otherwise, if deemed necessary, in order to remain an active patient at Johnson Health Center and its participating agencies.

I, the undersigned, verify that the information provided as part of the Johnson Health Center Sliding Fee Application is true and accurate. If the information is determined to be false and misleading, I understand that the Johnson Health Center has the right to discontinue my sliding fee rate and I will pay the full fee.

This release expires in one year.

Printed Name: _____

Signature: _____

Date: _____

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Medication Assistance Program (MAP)

The MAP is specifically designed to help those who are currently without prescription coverage needing assistance with their maintenance medications. JHC staff coordinates with the pharmaceutical companies to access medicine on your behalf. There is a fee of $5.00 for every medicine received and this can be paid by cash, check or credit card.
An application is needed for each medication. Your signature is required to process the application with the appropriate pharmaceutical company. **It can take up to 4 to 6 weeks to start receiving your medications.** If you have questions about the MAP, please contact the MAP Coordinator at (434)947-5967 ext. 1243 or ask to speak to Kelly McConnell after your appointment with your provider.

Checklist

In order to complete applications, you will need to turn in ALL documentation of income. All documentation needs to be from the current year. This may include, but is not limited to, any items that pertain to you on this list:

- Last month's pay stubs: must be consecutive and a full month
- Current year tax return 1040 for or schedule C if self-employed
- 4506T if you do not file taxes
- Child support documentation
- Unemployment award letter
- Pension or retirement award letter
- TANF award letter
- Food stamps award letter
- General relief award letter
- Letter of support

Please speak with your provider or contact Kelly McConnell
at (434)947-5967 ext. 1243 for more MAP information.

This Page for Office Use Only

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Family Size: _____ Income: _____

After examination of this applicant's family size, situation, and financial information, it is my decision that this application is:

- ☐ Approved at the rate of:
  - ☐ A ☐ B ☐ C ☐ D
- ☐ Approved for OB Prenatal with a total cost of _____
- ☐ For children under age 18; ineligible for Medicaid:
- ☐ Does not meet citizenship or immigration status requirements
- ☐ Other: _____

- ☐ Denied, Reason: _____

For the Following Program(s):

- ☐ Adult Medical Services
- ☐ Pediatric Medical Services
- ☐ OB/Prenatal/Gyn Services
- ☐ Dental Services
- ☐ Behavioral Health Services
- ☐ Medication Assistance Program (MAP)

This status shall remain in effect from _____ to _____ unless otherwise noted, at which time the applicant's financial situation will be reviewed to evaluate eligibility and classification.

Comments:

_____

_____

_____

_____

_____ _____

Reduced Fee Coordinator Date

Staff Use: Data Entered into EMR By _____ Date _____

This Page for Office Use Only

Page 1

Patient Information

Comments:

Guarantor/Responsible Party

Comments:

Page 2

Members of the Household

Comments:

Household Income

Comments:

Primary Medical Insurance Information

Comments:

Secondary Medical Insurance Information

Comments:_____

Emergency Contact

Page 3

Authorization for Treatment

□ Patient Declined

Authorization for Payment

□ Patient Declined

The patient made aware that declination means the he/she will receive a bill for all services provided?

Yes or No

Authorization to Leave Messages

□ Patient Declined

Notice of Privacy Practices

□ Patient Declined

Patient Rights & Responsibilities

□ Patient Declined

Pages 4 & 5

Reduced Fee Release of Information & Reduced Fee

Comments:

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