Charles Drew
HEALTH CENTER, INC.
"Growing a Healthy Community"

This Box for Staff Use Only:
Careful Contact: ☐ Yes ☐ No
School-Based: ☐ Yes ☐ No
Barrier: _____

PATIENT REGISTRATION & CONSENT TO TREAT FORM

All information requested within this form is essential to ensure quality patient care or required by federal law. It will be kept private and confidential as a part of the patient's medical record.

SECTION I: PATIENT INFORMATION AND DEMOGRAPHICS

First Name: _____ Last Name: _____

Preferred Name: _____ Middle Initial: _____

Social Security Number (SSN): _____ Date of Birth (mm/dd/yyyy): _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Language: _____ Interpreter Needed?: ☐ Yes ☐ No

Please fill out any/all contact methods. Check box for preferred contact method:

☐ Cell Phone: _____ May we leave a voicemail? ☐ Yes ☐ No

☐ Alt. Phone: _____ May we leave a voicemail? ☐ Yes ☐ No

Email Address: _____

Please check which of the following best describes your sex assigned at birth:

☐ Male ☐ Female

Please check which of the following best describes your gender identity:

☐ Male ☐ Female ☐ Transgender male/ female-to-male ☐ Transgender female/ male-to-female

☐ Choose not to disclose ☐ Don't know/Not applicable

Please check which of the following best describes your sexual orientation:

☐ Straight/heterosexual ☐ Lesbian, gay or homosexual ☐ Something else ☐ Bisexual

☐ Choose not to disclose ☐ Don't know/Not applicable

Please check which of the following best describes your pronouns:

☐ He, Him, His ☐ She, Her, Hers ☐ They, Them, Theirs ☐ Ze, Hir

☐ Decline to answer ☐ Unknown ☐ Other: _____

Please check which of the following best describes your housing status:

☐ Own ☐ Rent ☐ Public housing (high rise or low rise) ☐ Homeless *(see below)*

If you are homeless, please further describe your housing status:

☐ Homeless shelter ☐ Street homeless ☐ Transitional ☐ Doubling up

☐ Permanent supportive housing ☐ Other homeless: _____

Please answer the following questions:

Are you a veteran? ☐ Yes ☐ No

Are you a migrant farm worker? ☐ Yes ☐ No ☐ Seasonal

Are you attending school? ☐ Yes ☐ No

If yes, which school are you attending: _____

Please check which of the following best describes your race. Please only select one:

☐ American Indian or Native Alaskan ☐ Asian ☐ Black or African American ☐ Native Hawaiian

☐ Pacific Islander ☐ White ☐ More than one race ☐ Unknown, not listed, or refuse to report

Please check which of the following best describes your ethnicity. Please only select one:

☐ Hispanic, Latino, or Chicano ☐ Non-Hispanic, Latino, or Chicano ☐ Refuse to report

Please check which of the following best describes your primary medical coverage type. Please select only one:

☐ Medicaid ☐ Medicare ☐ Private or commercial insurance (including through Marketplace) ☐ None or uninsured

SECTION II: PATIENT HOUSEHOLD INFORMATION

Please **MARK** your family size and household income range (first find family size then find income range in same row)

Family Size	Annual Income Ranges					
1	☐ $0-$15,060	☐ $15,061-$18,825	☐ $18,826-$22,590	☐ $22,591-$26,355	☐ $26,356-$30,120	☐ Over $30,121
2	☐ $0-$20,440	☐ $20,441-$25,550	☐ $25,551-$30,660	☐ $30,661-$35,770	☐ $35,771-$40,880	☐ Over $40,881
3	☐ $0-$25,820	☐ $25,821-$32,275	☐ $32,276-$38,730	☐ $38,731-$45,185	☐ $45,186-$51,640	☐ Over $51,641
4	☐ $0-$31,200	☐ $31,201-$39,000	☐ $39,001-$46,800	☐ $46,801-$54,600	☐ $54,601-$62,400	☐ Over $62,401
5	☐ $0-$36,580	☐ $36,581-$45,725	☐ $45,726-$54,870	☐ $54,871-$64,015	☐ $64,016-$73,160	☐ Over $73,161
6	☐ $0-$41,960	☐ $41,961-$52,450	☐ $52,451-$62,940	☐ $62,941-$73,430	☐ $73,431-$83,920	☐ Over $83,921
7	☐ $0-$47,340	☐ $47,341-$59,175	☐ $59,176-$71,010	☐ $71,011-$82,845	☐ $82,846-$94,680	☐ Over $94,681
8	☐ $0-$52,720	☐ $52,721-$65,900	☐ $65,901-$79,080	☐ $79,081-$92,260	☐ $92,261-$105,440	☐ Over $105,441

SECTION III: INSURANCE INFORMATION

Insurance Name: _____ Policy number/Enrollment ID: _____

Group ID: _____ Member ID: _____

SECTION IV: EMERGENCY CONTACT INFORMATION

Emergency Contact: _____

Relationship to Patient: _____ Phone Number: _____

How did you hear about Charles Drew Health Center, Inc.? _____

SECTION V: FINANCIAL RESPONSIBLE PARTY INFORMATION

Should match insurance card, if applicable. Only complete this section if the responsible party is different from patient.

First Name: _____ Last Name: _____

Preferred Name: _____ Middle Initial: _____

Social Security Number (SSN): _____ Date of Birth (mm/dd/yyyy): _____

Address: _____ City: _____ State: _____ Zip: _____

Please fill out any/all contact methods. Check box for preferred contact method:

☐ Cell Phone: _____ May we leave a voicemail? ☐ Yes ☐ No

☐ Alt. Phone: _____ May we leave a voicemail? ☐ Yes ☐ No

Email Address: _____

Preferred Language: _____ Interpreter Needed?: ☐ Yes ☐ No

I authorize release of information regarding continuation of care and/or any payments for services. I authorize a copy of this document may be used as the original document. I certify all information provided is true and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

CONSENT TO TREAT

1. **Authorization for Medical Treatment.** I do hereby acknowledge, agree, and give my consent for diagnosis, treatment, behavioral health treatment, dental treatment, as deemed necessary by Charles Drew Health Center, Inc. as indicated appropriate by my treating provider, their assistants and/or designees. This Authorization includes, but is not limited to, routine diagnostic procedures, outpatient and inpatient care, laboratory test, x-rays and other tests or procedures. I also authorize copies of the medical records to be released to other physicians and healthcare facilities as deemed necessary by any physician(s) or provider whose care I am under. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as result to examination and treatment received at this Facility. I acknowledge that my care is under the direction of my treating provider and the Charles Drew Health Center, Inc. facility will follow the instructions of my provider(s) in the position in said care.
2. **Patient Care.** I, the undersigned, agree to uphold my responsibilities to take charge of my health care, working with my provider and maintaining compliance with my providers designated care plan for my health and well being.
3. **Personal Valuables.** I accept full responsibility for all property in my possession. I understand that Charles Drew Health Center, Inc. maintains no responsibility for property that is personal and in my possession.
4. **Duration and Scope.** I understand this agreement will be valid for one year (12 months) from the date it is signed, unless I cancel it sooner. This agreement will apply to any care provided to the patient at any Charles Drew Health Center Inc. locations during the next year, unless the care provided requires additional consents by law.
5. **Physician and Staff Employment.** Some providers at Charles Drew Health Center Inc. may be independent contractors who use Charles Drew Health Center Inc. facilities to provide care to their patients ("Contractors"). As such, these various independent contractors may submit bills for the professional services they provide separate from the bill Charles Drew Health Center Inc. may submit. Contractors are responsible for their own actions and Charles Drew Health Center Inc. is not liable for their actions or failure to act.
6. **Assignment of Facility Benefits.** I hereby assign all insurance benefits and/or Medicare/ Medicaid benefits to Charles Drew Health Inc. and authorize direct payment to facility. This payment includes all payments for charges incurred during treatment, visit and observation at all clinics for Charles Drew Health Inc. I agree that I am responsible for the financial aspect of my healthcare and will maintain compliance for any and all insurance plans, Medicare/Medicare and any self-pay and/or sliding fee details. A photocopy of this agreement shall be as valid as the original.
7. **Assignment of Professional Benefits.** I hereby assign all insurance benefits and/or Medicare/ Medicaid benefits to all physician(s), therapist(s), and/or medical professionals providing services to me and authorize direct payment to physician(s) and therapist(s). I agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.

8. **Authorized Representative.** I hereby authorize Charles Drew Health Center Inc. and its facilities, its agents and representatives to act on my behalf to recover benefit claims, appeal adverse benefit determinations, and to take any action deemed necessary to obtain payment for services provided to me by said Facility(s).

9. **Statement of Responsibility.** I understand that I am financially responsible to Charles Drew Health Center Inc. as the patient, guardian, and conservator or insured for all charges not covered by the above assignments or programs. Charges may include medical insurance deductibles, co-insurance out-of-pocket expenses.

10. **Sliding Fee Discount Program Policy.** Charles Drew Health Center Inc. has a sliding fee discount program and I may ask about it at any time. There is an application process for sliding fee, and eligibility is based on family size, family income, and other special circumstances. I may request a sliding fee application at any time.

11. **Self-Payment.** I understand I may choose to not have Charles Drew Health Center Inc. bill my and/or the patient's insurance for a particular health care item or service provided to the patient, and instead choose to personally pay in full the cost of that health care item or service. To exercise this option, I must notify Charles Drew Health Center Inc. in a timely manner, complete additional forms, and pay all applicable charges promptly and in full.

12. **Authorization to Release Information to Insurance Company/Third Party Payer.** I hereby authorize Facility(s), any authorized healthcare provider, including Veterans Administration or governmental hospital, any insurance company or other person, institution, or organization to release my medical records to any person, corporation, workers compensation carrier, governmental agency (or representative thereof) which is or may be, liable under any contract or governmental program to this Facility, the patient, or a family member for all or part of the Facility(s) charge. This Facility will endeavor to protect the confidentiality of my medical records. However, the Facility shall not be liable by reason of its release of said medical records or any part thereof when responding in good faith to an apparently valid release. I authorize release of pertinent records to pharmaceutical companies as needed.

13. **Non-covered Medicare/Medicaid Services.** The Medicare and Medicaid Programs have certain charges that are excluded from coverage, including but not limited to: cosmetic surgery, non-medically related dental surgery, routine diagnostic workups, routine physical exams, and oral drugs. I acknowledge I am financially responsible for all charges incurred if my medical/dental chart indicates for any of the listed treatments or care as listed.

14. **Shadowing and Observation.** Some people involved in patient's care may be medical, nursing, or other health care personnel in training. I consent to their participation. Other non-Charles Drew Health Center Inc. staff members may observe the patient's care. I have the right to request that any of these individuals not participate in or observe the patient's care and this request will not affect the patient's care at Charles Drew Health Center Inc.

15. **Contact by Phone.** By providing Charles Drew Health Center Inc. with my land line and/or cell phone number(s), I give my express consent for Charles Drew Health Center Inc., its contractors, agents, and collection agents to contact me at these numbers, or at any number that I later acquire, and to leave live or pre-recorded messages or to send text messages regarding accounts or services. I understand that for greater efficiency, calls may be delivered by an auto-dialer.

16. **Advanced Instructions for Healthcare.** I understand that I may indicate in writing (Advanced Directions, i.e. Living Will and Durable Power of Attorney) my desire to receive, select, and/or define medical or surgical treatment or choose non-treatment Charles Drew Health Center Inc. will recognize such instructions in accordance with Nebraska and/or Iowa State law and the Facility(s) policies if either both Advance Direction statement(s) are provided to the Facility(s) so that a copy is filed with any medical record.

_____ *Please Initial.* I acknowledge notification of Charles Drew Health Center, Inc. Patient Rights and Responsibilities.

_____ *Please Initial.* I acknowledge notification of Charles Drew Health Center, Inc. Privacy Practices.

The undersigned certifies that he or she has read the foregoing, and all questions have been answered. The signee is the patient, patient's guardian, power of attorney, parent, or is duly authorized by or on behalf of the patient to execute the above and accept its terms.

Patient/Parent/Power of Attorney/Guardian Signature: _____ Date: _____

Responsible Party's Signature *(if not the same as patient/parent)*: _____

Insured's Signature: _____ Witness to Signature: _____

Patient unable to sign consent because: _____