CareSouth
MEDICAL & DENTAL

NEW PATIENT REGISTRATION FORM

In order to continue the variety of services offered at CareSouth Medical and Dental (CSMD) and to continue receiving grant funding as a Federally Qualified Health Center (FQHC), CSMD is required to collect demographic information on every patient we serve. The information you provide is confidential. Thank you for choosing CSMD as your health care provider.

First Name	**Middle Name**	**Last Name**	**Suffix**

Gender: □ Male □ Female	**Date of birth** (mm/dd/yyyy)	**Social Security Number**	**Marital Status:** □ Single □ Married □ Other _____

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

Home Phone:	**Work Phone:**	**Mobile/Cell Phone:**

Email Address:	**Contact Preference:** □ Home Phone □ Work Phone □ Mobile/Cell Phone □ Mail □ Portal

Race: □ Black or African American □ Caucasian □ American Indian or Alaska Native □ Asian □ Native Hawaiian or Other Pacific Islander □ Other _____	**Primary Language** □ English □ Spanish □ Sign Language □ Other _____

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Not Reported or Refused	**Sexual Orientation:** □ Heterosexual /Straight □ Homosexual, Gay or Lesbian □ Bisexual □ Uncertain □ Other _____

Gender Identity: □ Male □ Female □ Transgender Male/Female-to-male □ Transgender Female/Male-to-Female □ Non-Binary (identifying as any gender other than female or male) □ Uncertain □ Not Reported or Refused □ Other ___ _____

How did you hear about CSMD? □ CSMD Employee or Website □ Physician Referral □ Hospital/Clinic □ Patient □ Friend/Family □ HRSA/PCA Website □ Word of Mouth □ School □ Fair/Festival/Event □ Phonebook Advertisement: □ Newspaper □ TV □ Radio

EMERGENCY CONTACT INFORMATION

Patient's Relation to Contact: □ Child □ Parent □ Spouse □ Other _____

First Name:_____ **Middle Name:**_____ **Last Name:**_____

Street Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Mobile/Cell Phone:**_____ **Work Phone:**_____

GUARANTOR INFORMATION
(Financially Responsible Individual)

Guarantor is: □ If Patient is Guarantor (No need to complete the rest of this section) □ Person □ Company/Job

Patient's Relation to Guarantor: □ Child □ Parent □ Spouse □ Employer □ Other _____

First Name:_____ **Middle Name:**_____ **Last Name:**_____

Suffix:_____ **Social Security Number:**_____ **Gender:** □ Male □ Female

Date of birth (mm/dd/yyyy) :_____ **Marital Status:** □ Single □ Married □ Other _____

Street Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Mobile/Cell Phone:**_____ **Work Phone:**_____

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FAMILY INCOME AND SHELTER INFORMATION

We request income on all patients for governmental reporting purposes.
If eligible for the Sliding Fee Scale, please complete separate Sliding Fee Application

Income Period: □ Weekly □ Bi-weekly □ Monthly □ Quarterly □ Annually □ Other _____

Gross Household Income: $_____ **Number of individuals income supports:**_____ **Disabled:** □ Yes □ No

Homeless Status: □ Not Homeless □ Homeless Shelter □ Street □ Transitional □ Other___

Agricultural Worker Status: □ Migrant □ Not Migrant □ Seasonal **Veteran Status:** □ Yes □ No

INSURANCE INFORMATION

Please allow our staff to copy/scan your insurance card

PLAN # 1 Information

Insurance company:_____

Member ID #:_____ **Group #:**_____

Patient's Relation to Guarantor: □ Self □ Child □ Parent □ Spouse □ Employer □ Other_____

*******************If Patient is Guarantor (No need to complete the rest of this section)*****************************

First Name:_____ **Middle Name:**_____ **Last Name:**_____ **Suffix:**_____

Social Security Number:_____ **Gender:** □ Male □ Female

Date of birth (mm/dd/yyyy) :_____ **Marital Status:** □ Single □ Married □ Other _____

Street Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Email:_____

Home Phone:_____ **Mobile/Cell Phone:**_____ **Work Phone:**_____

PLAN # 2 Information

Insurance company:_____

Member ID #:_____ **Group #:**_____

Patient's Relation to Guarantor: □ Self □ Child □ Parent □ Spouse □ Employer □ Other_____

*******************If Patient is Guarantor (No need to complete the rest of this section)*****************************

First Name:_____ **Middle Name:**_____ **Last Name:**_____ **Suffix:**_____

Social Security Number:_____ **Gender:** □ Male □ Female Em**ail:**_____

Date of birth (mm/dd/yyyy) :_____ **Marital Status:** □ Single □ Married □ Other _____

Street Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Email:_____

Home Phone:_____ **Mobile/Cell Phone:**_____ **Work Phone:**_____

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PATIENT MEDICAL HISTORY

Patient Name: _____ **Age (Years):** _____ **Birth Date:** _____

Height: _____ **Weight:** _____ **BMI:** _____ **Frame:** _____

CONDITIONS: Check (√) conditions you have or had in the past:

____ AIDS
____ ALCOHOLISM
____ ANEMIA
____ ANOREXIA
____ APPENDICITIS
____ ARHTRITIS
____ ASTHMA
____ BLEEDING DISORDERS
____ BREAST LUMP
____ BRONCHITIS
____ BULIMIA
____ CANCER
____ CATARACTS
____ CHEMICAL DEPENDENCY
____ CHICKEN POX
____ DIABETES
____ EMPHYSEMA
____ EPILEPSY
____GLAUCOMA
____GOITER
____GONORRHEA
____GOUT
____HEART DISEASE
____HEART MURMUR
____HEPATITIS
____ HERNIA
____ HERPES
____HYPERTENSION
____HIGH CHOLESTEROL
____HIV POSITIVE
____KIDNEY DISEASE
____LIVER DISEASE
____MEASLES
____MIGRAINE HEADACHES
____MISCARRIAGES
____MONONUCLEOSIS
____MULTIPLE SCLEROSIS
____MUMPS
____PACEMAKER
____PNEUMONIA
____POLIO
____PROSTRATE PROBLEMS
____PSYCHIATRIC CARE
____RHEUMATIC FEVER
____SCARLET FEVER
____STROKE
____SUICIDE ATTEMPT
____THYROID PROBLEM
____TONSILLITIS
____TUBERCULOSIS
____TYPHOID FEVER
____ULCERS
____VAGINAL INFECTIONS
____VENERAL DISEASE

FAMILY HISTORY

♦ HYPERTENESION _____
♦ DIABETES _____
♦ BLEEDING DISORDERS _____
♦ HEART DISEASE _____
♦ STROKE _____
♦ ALCOHOLISM _____
♦ TB _____
♦ CANCER (SITE) _____
♦ OTHER _____

WOMEN ONLY:

♦ Date of last menstrual period: _____

♦ Date of last pap smear:_____

♦ Are you pregnant? □YES or □NO

♦ Number of children: _____

♦ Have you had a Mammogram?
□YES or □ NO

♦ Are you taking any type of birth control?
□YES or □ NO

What type? ____Pills ____Shots ____ Other

PAST MEDICAL HISTORY

Please list all previous operations (surgeries)/hospitalizations and date:

_____

_____

Have you ever had a blood transfusion? □Yes or □No If yes, please give approximate date: _____

List all past major medical problems:

_____

_____

MEDICATIONS & ALLERGIES

Are you taking any prescribed medications or over-the-counter medications? □Yes or □No
If yes, please list medications below:
List Medications/Dosage:_____

_____

List Allergies:_____

HEALTH HABITS – Please (√) and describe how much.

□ Caffeine _____
□ Tobacco _____
□ Drugs _____
□ Alcohol _____

SEXUAL ACTIVITY
Sexual Partner: □Male □Female □Both
Number of Lifetime Partners _____
History of STD's: _____

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FINANCIAL RESPONSIBILITY AGREEMENT

I/We_____ (name) hereby authorize CareSouth Medical and Dental (CSMD) to furnish all information regarding my medical history, diagnosis and treatment of myself or my child (if applicable) to an insurance company regarding my claims for benefits. If however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I/We agree to be responsible for the fee and cost involved in the treatment of the above named patient. I/We understand that fees for services are determined prior to service. Once seen by the provider, the provider may determine a need for additional services such as lab work or x-rays. I/We also understand that a procedure may be determined to be more complicated than expected, resulting in additional charges. I/We understand that I am responsible for any additional charge(s) for services as indicated by my provider. I/We authorize payment of medical benefits to CSMD.

_____ _____

Date **Patient or Guardian Signature**

Acknowledgement of Receipt of NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided CareSouth Medical and Dental's Privacy Practices ("Notice"):

- It tells me how CareSouth Medical and Dental will use my health information for the purposes of my treatment, payment for my treatment, and CareSouth Medical and Dental's care operations (TPO).
- The Notice also explains in more detail how CareSouth Medical and Dental may use and share my health information for other than treatment, payment and health care operations (TPO).
- CareSouth Medical and Dental will also use and share my health information as required/permitted by law.

Patient's Name _____

_____ _____

Date **Patient or Guardian Signature**

Acknowledgement of Receipt of PATIENT RIGHTS AND RESPONSABILITIES

I acknowledge that I have been provided CareSouth Medical and Dental's Patient Rights and Responsibilities.

Patient's Name _____

_____ _____

Date **Patient or Guardian Signature**

CONSENT TO TREATMENT:

I hereby request and consent to diagnostic procedures, tests, and CareSouth Medical and Dental (CSMD) treatment, family planning, birth control methods, and immunizations as deemed advisable by CSMD's professional staff. I am aware that a Physician, a Nurse Practitioner or a Behavioral Health Clinician may provide care. Health care services will be in my best interest, or the best interest of my child or legal charge. I understand that this consent to treatment will be in effect as long as I am seen at any of the CareSouth Medical and Dental clinic sites. I/We do hereby give my consent for treatment by CSMD. I may cancel this consent in writing.

Signed: **X**_____ _____

Patient Signature/Parent/Legal Guardian Signature (Please circle one) Date

Please print full name and relationship to patient if the patient cannot sign this document.

_____

Full name (print) Relationship

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SLIDING FEE DISCOUNT PROGRAM APPLICATION

Date: / /		
First Name:	Middle Name:	Last Name:

Household Size		
Name	**Date of Birth**	**Social Security Number**
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -

NOTE: To comply with federal regulations, in order to give you a discount on our medical-dental services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every six months. Please bring yearly income tax return, last month's paycheck stubs, copies of your social security-food stamps award letters, or other supporting documents you may receive as proof of family income. Only the family size and annual gross income will be used to determine your eligibility and calculate your discount.

Household Income

Name	**Amount**	**Frequency (Circle one)**	**Employer:**
You	$	Weekly Bi-weekly Monthly Yearly	
Spouse	$	Weekly Bi-weekly Monthly Yearly	
Children	$	Weekly Bi-weekly Monthly Yearly	
Other	$	Weekly Bi-weekly Monthly Yearly	
	$	Weekly Bi-weekly Monthly Yearly	
TOTAL	$	Weekly Bi-weekly Monthly Yearly	

Other Income	**You**	**Spouse**	**Children**	**Other**	**Subtotal**
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	$

Sliding Fee Scale:

Medical Nominal Fee for Scale "A" Office Visits only-$25, which also includes the following labs: 80053, 80061, 81001-81003 & 85025

Dental Nominal Fee for Scale "A" only-$25; which includes the following codes: D0120, D0140, D0145, D0150, D0170, D0180, D0210, D0220, D0230, D0240, D0270, D0272, D0274 & D0330. All other procedures are discounted at the following percentages:

A-85% Discount

B-80% Discount

C-60% Discount

D-40% Discount

E-20% Discount

F-0% Discount

(***Poverty Guidelines Chart Available at Patient's Request***)

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform CareSouth Medical and Dental if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of CareSouth Medical and Dental. I hereby acknowledge that I read the foregoing disclosure and understand it.

Last Name _____ First Name _____

Signature of Patient or Guardian _____ Date _____

FINANCIAL AND APPOINTMENT AGREEMENT

Thank you for choosing CareSouth Medical and Dental (CSMD) Clinic as your healthcare provider. We strive to offer quality and affordable services provided by qualified professionals. It is important that you understand your financial and appointment responsibilities, recommended treatment plan, the costs associated, and that some procedures may require referral to another dentist or specialist.

Medical/Dental or Specialist Referral: Your treatment may require services that cannot be provided at the CSMD Clinic. In this case, you will be referred to another specialist for completion of your treatment. Payment arrangements must be made with the specialist office prior to your first visit. Sliding fees may not apply to outside providers.

Payment Expectations: The CSMD Clinic provides many options for patients to minimize the financial barriers to healthy and complete care. As a courtesy the office staff will file to all insurances, including Medicaid. However, you will be expected to pay your estimated co-insurance at the time of service. If your insurance or Medicaid does not pay for part or all of the services, you are responsible for the billed amount. We realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in management of your account. If you show up without payment, your appointment will be rescheduled. True emergencies will be handled on a case-by-case basis.

Insurance and Medicaid: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. You understand that all charges are ultimately your responsibility even if insurance does not pay. Please be aware that some, and perhaps all, of the services provided may not be covered services and not considered reasonable and customary under the terms of your insurance policy. If you do not have insurance, CSMD will help find an available financial assistant program. If none is found, CSMD offers the sliding fee discount for those who qualify, please ask the Front Desk staff about the requirements. We do everything possible to keep our services affordable.

Emergencies: The CSMD Clinic will provide emergency services whenever possible. However, referral to another Specialty, or Primary Care provider may be necessary to accommodate your emergent needs, based on the severity of the emergency. When there is not availability on our schedule, we will keep a waiting list for those emergencies that want to schedule with our clinic. Or, we will schedule you for the next available time, which could be several days.

Lab Charges: Some procedures require the use of an outside Lab for services. You must pay in advance for Lab services. If you are on a sliding scale, the charges for Laboratory cases are discounted differently than the normal discounted percent for your sliding scale.

Scheduling, Cancelling and No-Showing for Appointments: The CSMD Clinic will make every effort to schedule your appointments according to your recommended treatment. Check-in is twenty (20) minutes prior to your scheduled appointment time. An appointment must be cancelled at least two (2) hours prior to the time of the appointment or will be considered a "No Show". Patients that arrive ten (15) minutes late for scheduled appointment will be asked to wait in the lobby while the Front Desk staff review the provider's schedule for availability to determine if the patient can be seen at that time or at a later time.

CSMD HIPAA / Patient's and Provider's Rights and Responsibilities. The CSMD Clinic provides copies of these policies. Patient acknowledges they have read and understand these policies.

Unattended Child: CSMD strive on patient's safety as well as their children. Any child age 0-17 must be accompanied by an adult at all times. Failure to abide by this policy will result in the appointment being rescheduled.

□ ***I HAVE READ*** the CSMD Clinic Financial and Appointment Policy and understand the services provided and my responsibilities as a CSMD patient. I authorize CSMD staff to provide services to me.

Last Name _____ First Name _____

Signature of Patient or Guardian _____ Date _____