# Cornell Scott Hill Health Center Registration Information

## PATIENT INFORMATION

Date:

Name:

Address:

City,State,Zip:

Preferred:

Pt ID # / MRN:

Sex: [ ]M [ ]F

Transgender [ ]

Other

Date of Birth:

Social Security #:

Marital Status: [ ]Married [ ]Domestic Parner [ ]Single [ ]Divorced [ ]Separated [ ]Widowed

## Housing Type:

Public Housing: Yes[ ] No [ ]

Nursing Home: Yes [ ] No [ ]

Group Home: Yes[ ] No [ ]

Homeless: Yes [ ] No [ ]

Phone: [ ]Home [ ]Work [ ]Other

OK to Call: Yes [ ] No [ ]

OK to Leave Message: Yes [ ] No [ ]

Phone: [ ]Home [ ]Work [ ]Other

OK to Call: Yes [ ] No [ ]

OK to Leave Message: Yes [ ] No [ ]

I give CS-HHC permission to contact me at the following e-mail address:

Primary Language: English

Translation Required:

## ADDITIONAL INFORMATION

Race: [ ] White/Caucasian [ ]Black/African American [ ]More than One Race [ ]Asian [ ]Other Pacific Islander [ ]Native Hawaiian [ ]American Indian/Alaskan Native [ ] Decline to Report

Ethnicity: [ ] Hispanic [ ]Non-Hispanic

U.S. Citizen: [ ] US Citizen [ ] Non-US Citizen [ ] Decline to Report

Veteran Status: [ ] Veteran [ ]Non-Veteran

Education Status: [ ] No High School Diploma [ ]High School Diploma [ ] College Degree [ ]Master's Degree [ ]Doctorate

Employment status: [ ] Full Time [ ] Part Time [ ] Unemployed [ ] Self Employed [ ] Retired [ ] Student [ ] Child

## Family Size/Income (voluntary for all patients for grant)

Family Size:

Annual Income:

## EMERGENCY CONTACT - Name, Relationship, Phone

Does this person knowthat you are a patient?: [ ] Yes [ ] No

## GUARANTOR *Who will be responsible for any self-pay balance?*

[ ]Same as Patient

Name:

Address:

City,State:

Phone:

Alt Phone:

Social Security #:

Date of Birth:

## PRIMARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party:

Insured Phone:

Company:

Relationship to Primary Insured/Guarantor:

Social Security #:

Insured ID:

Policy Group:

Date of Birth:

## SECONDARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party:

Insured Phone:

Company:

Relationship to Primary Insured/Guarantor:

Social Security #:

Insured ID:

Policy Group:

Date of Birth:

I certify the above information is correct.

Signature: ____________________

Date: ____________________

Identity Verified (two required): [ ] Driver's License [ ] State ID [ ] Passport [ ] Insurance Card [ ] Other ____________

By: ____________________ Date: ____________ Title: ____________________

## Terms of Service

| For Office Use Only: |
| --- |
| CS-HHC #:______ |

**Consent to Basic Treatment and Diagnostic Procedures:** I agree to examination, diagnosis and treatment (including immunizations and vaccines) at any Cornell Scott-Hill Health Center site. I agree to any x-rays, laboratory tests (including HIV/AIDS test), and any other medical, dental or behavioral health procedure ordered by a licensed provider. You may take my picture. I understand you will keep my picture in my health record as protected health information (PHI). You may obtain my medication history from any pharmacy. I understand that, except in an emergency, all special or invasive procedures (i.e. blood transfusions or use of anesthetics) will be discussed with me by my provider and that a special written consent form may be required.

**Consent to Release Medical Information:** You may use and disclose my protected health information (PHI) to carry out my treatment, to obtain payment, and to conduct health center business. My PHI may include medical, dental, behavioral health or any other related information. It may include coded medical, dental, or behavioral health informatio and charges to my health insurance plan. My protected health information may be disclosed to my health insurance plan if necessary. My PHI may be disclosed to other health agencies or institutions involved in my care. I understand that I can take back my consent at any time by writing to the Privacy Officer, and that you are not responsible for disclosing my PHI prior to withdrawing my consent.

**Assignment of Insurance Benefits:** I certify the information I gave is correct to the best of my knowledge. This information may be used to apply for payment by my health insurance, including Medicare, Medicaid (Title 19), any federal or state healthcare program, or private insurance. I authorize you to submit claims for payment of benefits on my behalf, and I authorize the payments to go directly to you or any provider under contract with you.

**Responsibility for Payment:** I agree to pay for charges not covered by Medicare, Medicaid (Title 19), any federal or state healthcare program, or private insurance. I will be responsible for payment of co-payments, deductibles, charges considered to be beyond usual, customary and reasonable, or uncovered services. I understand that you have a policy that under certain circumstances, you may refuse to provide services if I do not pay my bills. I agree to be responsible for past due amounts. If I have made a claim for damages arising from injuries for which I am being treated by you, I authorize my attorney to pay all unpaid medical bills owed to you out of any proceeds that I receive from a judgment or settlement of the claim. I agree that such medical bills shall be paid before any money is paid to me personally. I also agree to maintain my account current until a final resolution of the case is reached.

**Registration for a Patient Who is not Signing This Form:** I certify that I have legal suthority to register the patient named above and agree to the Terms of Service. I agree to provide whatever documentation you require to prove my identity and to prove my authority to sign this form on behalf of a minor, an incapapcitated adult or other person.

**Notice of Privacy Practices:** I understand that specific information regarding the uses and disclosures of my medical information can be found in your Notice of Privacy Practices which has been made available to me, and which I have a right to review before I sign this form. I also understand that you have a right to change you Notice of Privacy Practices, and that I may obtain a revised copy on your website, www.cornellscott.org or from the Patient Registration area. I understand I have the right to request that you restrict how my protected health information is used and disclosed for treatment, payment and healthcare operations. I also understand that you are not required to agree to my requested restrictions. However, if you agree to a requested restriction, you are obligated by it.

I HAVE READ THIS FORM, HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS, AND I UNDERSTAND ITS CONTENTS.

_________________________________________ Signature of Parent or Legal Guardian

__________________ Date