Patient Registration

PRAIRIE STAR Health Center
non-profit • FQHC

PATIENT INFORMATION

Last Name (Legal)	First Name (Legal)	Middle Initial	Preferred Name (Optional)

Date of Birth

Social Security #

Marital Status (Legal)
☐ Single ☐ Married ☐ Widowed
☐ Partner ☐ Divorced/Separated

Gender at Birth
☐ Male ☐ Female

Billing Address (with Apt. # if applicable)	PO Box	City	State	Zip Code

Home Phone #

Cell Phone #

Employment Status (Select all that apply)
☐ Full Time ☐ Part Time
☐ Disabled ☐ Retired
☐ Unemployed ☐ Student
☐ Military - Active Duty

Employer Name

Employer Phone #

Contact Preference
☐ Phone Call→ ☐ Home ☐ Cell
☐ Text Message
☐ No Reminders

Best Time to Contact
☐ Morning
☐ Afternoon
☐ Evening

Email Address (required for patient portal access and message reminders)

Preferred Pharmacy
☐ **PSHC Pharmacy or** ☐ ______________________

Race
☐ White ☐ Asian Indian ☐ Korean ☐ Native Hawaiian ☐ Samoan
☐ Black/African American ☐ Filipino ☐ Vietnamese ☐ Other Pacific Islander ☐ American Indian/Alaska Native
☐ Other Asian ☐ Japanese ☐ Chinese ☐ Guamanian or Chamorro ☐ Unreported/Choose not to disclose

Ethnicity
☐ Hispanic or Latino/a
☐ Mexican American, Chicano/a
☐ Puerto Rican
☐ Cuban
☐ Another Hispanic, Latino/a or Spanish origin
☐ Not Hispanic, Latino/a or Spanish origin
☐ Unreported/Choose not to disclose

Are you a migrant or seasonal agricultural worker?
☐ Yes ☐ No

Are you a US Veteran?
☐ Yes ☐ No

Are you homeless?
☐ Yes ☐ No

Primary Language Spoken
☐ English
☐ Spanish
☐ Other ______________________
☐ Interpreter Needed

INSURANCE INFORMATION (We will need a copy of your insurance card(s))

Primary Health Insurance	**Secondary Health Insurance**
Health Insurance Company	Health Insurance Company
Name of Policy Holder (if different from above)	Name of Policy Holder (if different from above)
Policy Holder's date of birth (if different from above)	Policy Holder's date of birth (if different from above)
Policy Holder's relationship to Patient (if different from Self) ☐ Spouse ☐ Parent ☐ Other ______________	Policy Holder's relationship to Patient (if different from Self) ☐ Spouse ☐ Parent ☐ Other ______________
Primary Dental Insurance	**Secondary Dental Insurance**
Dental Insurance Company	Dental Insurance Company
Name of Policy Holder (if different from above)	Name of Policy Holder (if different from above)
Policy Holder's date of birth (if different from above)	Policy Holder's date of birth (if different from above)
Policy Holder's relationship to Patient (if different from Self) ☐ Spouse ☐ Parent ☐ Other ______________	Policy Holder's relationship to Patient (if different from Self) ☐ Spouse ☐ Parent ☐ Other ______________
Primary Vision Insurance	**Secondary Vision Insurance**
Vision Insurance Company	Vision Insurance Company
Name of Policy Holder (if different from above)	Name of Policy Holder (if different from above)
Policy Holder's date of birth (if different from above)	Policy Holder's date of birth (if different from above)
Policy Holder's relationship to Patient (if different from Self) ☐ Spouse ☐ Parent ☐ Other ______________	Policy Holder's relationship to Patient (if different from Self) ☐ Spouse ☐ Parent ☐ Other ______________

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EMERGENCY CONTACT (EC) AND PATIENT CONSENT TO SHARE PERSONAL HEALTH INFORMATION (PHI)

By selecting, Personal Health Information (PHI), I authorize PrairieStar to share my PHI with the person(s) below. I understand this authorization is **VOLUNTARY.** I understand that once my information is disclosed, it may be redisclosed by the recipient, and the information may not be protected by Federal privacy laws or regulations. I understand that this consent will remain in effect until I cancel it in writing or this registration form is updated. Emergency Contact (EC) designates 911 contact only; no PHI will be shared.

Name	Phone	Relationship to Patient	
Name	**Phone**	**Relationship to Patient**	☐ EC ☐ PHI
Name	**Phone**	**Relationship to Patient**	☐ EC ☐ PHI
Name	**Phone**	**Relationship to Patient**	☐ EC ☐ PHI

GUARANTOR (Financially Responsible Individual) and/or LEGAL GUARDIAN INFORMATION

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

☐ Biological Parent ☐ Legal Guardian ☐ Company / Employer ☐ DCF / St. Francis ☐ Other:________

Responsible Party (Biological Parent or Legal Guardian)

First Name	Middle Initial	Last Name	
Social Security #	**Date of Birth**	**Gender** ☐ **Male** ☐ **Female**	
Address	**City**	**State**	**Zip Code**
Home Phone #	**Cell Phone #**	**Work Phone #**	
Email Address	**Employer Name**		

HOUSEHOLD INCOME GUIDELINES

PrairieStar Health Center (PrairieStar) is a Federally Qualified Health Center (FQHC). We receive federal funding and grants. As part of this funding, we are required to collect income data on all patients at least once a year. This data is used to set up programs to meet our patient's needs.

PLEASE SELECT THE INCOME THAT BEST DESCRIBES YOUR SITUATION

Number in Household	1	2	3	4	5	6	7	8
Annual Income Under	☐ $15,650.00	☐ $21,150.00	☐ $26,650.00	☐ $32,150.00	☐ $37,650.00	☐ $43,150.00	☐ $48,650.00	☐ $54,150.00
Annual Income Between	☐ $15,651.00 $23,475.00	☐ $21,151.00 $31,725.00	☐ $26,651.00 $39,975.00	☐ $32,151.00 $48,225.00	☐ $37,651.00 $56,475.00	☐ $43,151.00 $64,725.00	☐ $48,651.00 $72,975.00	☐ $54,151.00 $81,225.00
Annual Income Between	☐ $23,476.00 $27,387.50	☐ $31,726.00 $37,012.50	☐ $39,976.00 $46,637.50	☐ $48,226.00 $56,262.50	☐ $56,476.00 $65,887.50	☐ $64,726.00 $75,512.50	☐ $72,976.00 $85,137.50	☐ $81,226.00 $94,762.50
Annual Income Between	☐ $27,388.50 $31,300.00	☐ $37,013.50 $42,300.00	☐ $46,638.50 $53,300.00	☐ $56,263.50 $64,300.00	☐ $65,888.50 $75,300.00	☐ $75,513.50 $86,330.00	☐ $85,138.50 $97,300.00	☐ $94,763.50 $108,300.00
Annual Income Over	☐ $31,301.00	☐ $42,301.00	☐ $53,301.00	☐ $64,301.00	☐ $75,301.00	☐ $86,331.00	☐ $97,301.00	☐ $108,301.00

PAY AGREEMENT

I agree to promptly and fully pay any charges for services I receive at PrairieStar. I understand I will be responsible for any charges not paid by my insurance. I understand I am responsible to check with my insurance provider to see which services are covered. I understand that delinquent accounts are subject to collection activity, including referral to a collection agency.

EXTERNAL PRESCRIPTION HISTORY

PrairieStar uses an electronic health record system that allows electronic prescribing of medications. Medications are sent to the pharmacy through a secure electronic prescription connection which improves the timely and accurate transmission of medication information. I agree that PrairieStar may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes. ***By initialing the box, I <u>DO NOT</u> authorize PrairieStar to request prescription medication history.***

☐

ASSIGNMENT OF BENEFITS

I hereby assign and authorize direct payment to PrairieStar of all insurance payments or other third party payers.

CONSENT FOR TREATMENT

I hereby request and give consent for the healthcare professional at PrairieStar to provide medical, dental, vision and behavioral health treatment to me and/or my family.

AUTHORIZATIONS TO RELEASE INFORMATION

I authorize PrairieStar to release any health information that may be necessary for either medical care or for processing of insurance benefits.

I request payment of authorized Medicare/Medigap/Medicaid benefits to PrairieStar and authorize release of health information necessary for processing insurance benefits to Centers of Medicare and Medicaid and other insurance agents.

I hereby certify that the above information is true, and that I have read, fully understand, and accept all terms of the foregoing guidelines.

SIGNATURE OF PATIENT, GUARANTOR &/OR LEGAL GUARDIAN	DATE

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PAYMENT ARRANGEMENTS, NON-COVERED SERVICES & CO-PAY

As your health center provider, our relationship is with you and not your insurance carrier. PrairieStar will file your claims to your insurance; however, **you are the sole responsible party for all charges that remain after insurance payments.** Failure to provide PrairieStar with current, accurate insurance information will result in all charges becoming the responsibility of the patient/responsible party. **All co-pays, co-insurance, and sliding scale nominal fees are due prior to services being rendered.** These payments do not guarantee payment in full. Statements will be mailed for charges exceeding the initial payment made. For patients with Medicare or Medicaid, please be advised there may be an applicable co-pay for services rendered. If we are not contracted with your insurance company, you will be 100% responsible for the payment at the time of service.

PrairieStar wants to work with you to meet your healthcare needs at affordable costs. Please contact the patient account representatives at (620) 663-8484 if you need to set up payment arrangements for your account balance. PrairieStar accepts payments in the office, over the phone, on the Patient Portal, or online at https://www.prairiestarhealth.org. For your convenience, you can also set up an automatic/recurring ACH agreement.

NON-PAYMENT FOR SERVICES

If no payment or payment arrangement has been made with PrairieStar after 90 days from the first statement date, your account will be turned over to an outside collection agency. All patients turned to an outside collection agency are required to make either a $75 payment (**this is in addition to any co-pays, co-insurance, and sliding scale nominal fees**) at the time of service for all future appointments until the collection balance has been paid in full or set up an automatic/recurring payment agreement with the Business Office via checking, savings, or debit/credit card.

RETURNED CHECKS/ACH

PrairieStar charges a **$30 fee for all checks and $15 fee for all ACH transactions returned** as non-sufficient funds. The original payment amount, as well as the returned check/ACH fee, will be added to your next statement balance. Checks/ACH's will no longer be accepted on your account and all future payments must be made by cash, debit/credit card, or money order.

APPOINTMENT POLICY

If you are **5 minutes late** for an appointment, you may have to be rescheduled. Your provider will attempt to work you back into the schedule, but this may be after your scheduled appointment time. If we are unable to work you in, you will have to be rescheduled, and this will count as a *missed appointment without notice* . If you miss **two (2)** scheduled **dental** appointments within a **12 month period of time** without notifying PrairieStar prior to the previous business day, you will be placed on **same-day scheduling**.

YOUR RIGHTS REGARDING ELECTRONIC HEALTH INFORMATION TECHNOLOGY

PrairieStar participates in electronic Health Information Technology (HIT). This technology allows a provider or a health plan to make a single request through a Health Information Organization (HIO), to obtain electronic records for a specific patient from other HIT participants for purposes of treatment, payment, or healthcare operations. HIOs are required to use appropriate safeguards to prevent unauthorized uses and disclosures.

You have two options with respect to HIT. First, you may permit authorized individuals to access your electronic health information through an HIO. If you choose this option, you do not have to do anything.

Second, you may restrict access to all of your information through an HIO (except as required by law). If you wish to restrict access, you must submit the required information either online at http://www.KanHIT.org or by completing and mailing a form. This form is available at http://www.KanHIT.org. You cannot restrict access to certain information only; your choice is to permit or restrict access to all of your information. If you have questions regarding HIT or HIOs, please visit http://www.KanHIT.org for additional information.

If you receive healthcare services in a state other than Kansas, different rules may apply regarding restrictions on access to your electronic health information. Please communicate directly with your out-of-state healthcare provider regarding those rules.

PATIENT CONSENT FOR SCRIBE AND TELEHEALTH SERVICES

I understand that PrairieStar provides telehealth services and uses audio scribe services. I give my permission to be audio recorded during my visits. I acknowledge that my participation is voluntary and that I may revoke this consent at any time by providing PrairieStar a 30-day written notice.

PATIENT ACKNOWLEDGEMENT AND NOTICE OF PRIVACY PRACTICES

I have been given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that PrairieStar reserves the right to change the terms of this notice periodically, and that I may contact PrairieStar at any time to obtain the most current copy of this notice.

I hereby acknowledge that I have read, fully understand and accept all terms of the financial guidelines and policies stated above.

SIGNATURE OF PATIENT, GUARANTOR &/OR LEGAL GUARDIAN	DATE

For Office Use Only									
Forms		Photo		PCP		IE		VFC	