Registration and Financial Evaluation Record

Patient Information

Date of Registration / Time	Last Name	First Name	Middle Name	Patient Chart#
SSN#	Date of Birth	Age	Sex	Patient ID #
Address / Apt #		City, State, Zip		
Home Phone	Work Phone	Work Status	Employer Name	
Patient Email Address	Marital Status	Patient Sliding Fee Scale		

Guarantor Information

Account Balance	Last Name	First Name	Middle Name
SSN#	Date of Birth	Relationship to Patient	Sex
Address / Apt #		City, State, Zip	
Home Phone		Guarantor Email Address	Account Number

Insurance Information

Primary Insurance Plan Name	Primary Policy # / Group #	Primary Subscriber Name / DOB
Secondary Insurance Plan Name	Secondary Policy # / Group # /	Secondary Subscriber Name / DOB /

Emergency Contact Information

Last Name	First Name	Middle Name	
SSN#	Relationship to Patient	Work Phone	
Home Phone		Guarantor Email Address	Account Number

Other Information

Please Select your income range

- ☐ ☐ Less than $11,670
- ☐ ☐ $11,670 to $19,999
- ☐ ☐ $20,000 to $34,999
- ☐ ☐ $35,000 to $49,999
- ☐ ☐ $50,000 to $74,999
- ☐ ☐ $75,000 to $99,999
- ☐ ☐ $100,000 or more

Or

What is your income:___________

Annual/Weekly/Bi-Weekly/Monthly

Additional information

Homeless	Y	N
Worker Status: Migrant/ Seasonal Worker	Y	N
Public Housing	Y	N
Disabled Veteran	Y	N
Disabled	Y	N

Please specify disability: ____________________________

What is your race?

- ☐ ☐ American Indian or Alaska Native
- ☐ ☐ Asian
- ☐ ☐ Black or African American
- ☐ ☐ Native Hawaiian or Other Pacific Islander
- ☐ ☐ White
- ☐ ☐ Other

What is your ethnicity?

- ☐ ☐ Hispanic or Latino or Spanish Origin
- ☐ ☐ Not Hispanic or Latino or Spanish Origin

GENERAL CONSENT FOR TREATMENT, RELEASE OF MEDICAL INFORMATION AND AUTHORIZATION FOR INSURANCE PAYMENT

1. I, the undersigned or legal guardian grant permission as indicated below to undergo all necessary tests, treatments and other procedures or studies required for the diagnosis by the medical staff and other employees of Jessie Trice Community Health Center, Inc.
2. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment and examination by Jessie Trice Community Health Center, Inc
3. I consent to the release of medical information to other institutions or agencies accepting the patient for medical or institutional care, and consent to the release of medical information to patient's insurer and give permission to release data (both medical and personal) to such government agencies as is required of Jessie Trice Community Health Center, Inc by law, rules, regulations, or by consent.
4. I consent to the release of medical and financial information for auditing purposes.
5. I hereby authorize payment to Jessie Trice Community Health Center, Inc. of benefits due to me in my pending claim and/or MAJOR MEDICAL BENEFITS, otherwise payable to me, but not to exceed the health center and/or physician regular charges for this period of treatment. I agree that a copy of this authorization is as valid as the original. I understand that if my insurance does not approve the charges for this visit, I am fully responsible to Jessie Trice Community Health Center, Inc. for payment.

6. MEDICARE PATIENTS ONLY: I authorize any holder of medical or other information about me to release to Centers for Medicare and Medicaid (CMS) or its intermediaries or carriers, any information needed for this or any subsequent Medicare claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party that accepts assignment for such claim.
7. BY SIGNING THIS DOCUMENT, I ATTEST THAT ALL INFORMATION IS TRUE AND CORRECT AND I WILL NOTIFY JESSIE TRICE COMMUNITY HEALTH CENTER, INC OF ANY CHANGES TO MY INSURANCE, INCOME OR CONTACT INFORMATION.

Name of Patient	JTCHC Representative (PLEASE PRINT)
Signature of Patient or Legal Guardian	JTCHC Representative's Signature