REGISTRATION FORM

PATIENT INFORMATION

Patient Name_____ Social Security Number_____
First *Middle* *Last*

Date of Birth_____ Sex at Birth (male or female)_____

Address_____
Street City, State, Zip

Email Address_____

Home Phone Number_____

Cell Phone Number_____

Can we leave a message? ❑ Yes ❑ No

Last Grade Completed_____

Public Housing ❑Yes ❑ No

Email Address_____

Preferred Method of Contact
❑Electronic portal (via secure messaging)
❑voicemail ❑email ❑text

Ethnicity ❑Hispanic ❑Non-Hispanic ❑Decline to answer

Race ❑Black/African American ❑Caucasian (White)
❑American Indian/Alaskan Native ❑Asian
❑Native American Pacific Islander ❑Native Hawaiian
❑Multiple Races ❑Decline to answer

Gender Identity (*Check off one box only please)*
❑Male
❑Female
❑Transgender Male (Female-to-Male)
❑Transgender Female (Male to Female)
❑Other
❑Decline to answer

Sexual Orientation (*Check off one box only please)*
❑Straight
❑Gay
❑Lesbian
❑Bi-sexual
❑Other
❑I don't know
❑Decline to answer

Employer_____

Veteran ❑Yes ❑No

Country of Origin_____

Marital Status ❑Single ❑Married ❑Separated ❑Divorced ❑Widow

Language Preference_____

Name of Pharmacy_____

FOR CHILDREN

Mother/Guardian Name_____ Phone Number_____

Father/Guardian Name_____ Phone Number_____

Children live with ❑Mother ❑Father ❑Guardian

Mother's Maiden Name_____

The persons listed above may sign consent for treatment, on behalf of my child

_____ _____ _____
Patient/Guardian Signature Signature of Legal Representative Date

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Name_____ Relation to patient_____ Phone Number_____

Name_____ Relation to patient_____ Phone Number_____

Name_____ Relation to patient_____ Phone Number_____

Name_____ Relation to patient_____ Phone Number_____

Name_____ Relation to patient_____ Phone Number_____

***The persons listed above can NOT sign consent for treatment, on behalf of my child.**

REGISTRATION FORM

IN CASE OF EMERGENCY

Emergency Contact Name_____ Phone Number_____

Relationship to patient ❑Self ❑Spouse ❑Child ❑Other (please specify)_____

FINANCIAL/INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Name of person responsible for bill_____ Date of Birth_____

Social Security Number_____ Phone Number_____

Address_____

Street City, State, Zip

Household Income $_____
❑Yr. ❑Mo. ❑Wk. ❑Bi-wkly

Number of Dependents
spouse/children under 18

Primary Insurance_____ Policy Holder Name_____ Policy Number_____

Secondary Insurance_____ Policy Holder Name_____ Policy Number_____

Patient's relationship to Insured ❑Self ❑Spouse ❑Child ❑Other (please specify)_____

Complete Below for Private Insurance Only

Employer Name Employer Phone Number Group #

GENERAL CONSENT FOR TREATMENT AND PRIVACY NOTICE

The above information is true to the best of my knowledge. I hereby give Optimus Health Care and its medical providers my consent for any necessary medical evaluation and treatment.

I acknowledge that I have reviewed the Optimus Health Care

□ Notice of privacy practice

□ Failure to Keep Appointments policy and,

□ Patient Bill of Rights in the language of my understanding

I also understand that I may request another copy at any time. I authorize Optimus Health Care, Inc. or insurance company to release any information required to process my claims. I understand that I am financially responsible for any balance due, regardless of insurance or third party accommodations.

Patient/Guardian Signature Signature of Legal Representative Date

REGISTRATION FORM

Patient Bill of Rights

All Optimus Health Care, Inc. patients have the rights and responsibilities outlined below:

1. The patient has the right to receive complete information and confidentiality regarding his/her medical condition and treatment plan.
2. The patient has the right to complete information on the services and off-hour coverage system of Optimus Health Care, Inc.
3. The patient has the right to complete information regarding research projects that might include him/her, and the right to refuse to participate in such projects.
4. The patient has the right to his/her complete medical records upon request.
5. The patient has the right to complete information regarding fees, charges and reimbursement policies of Optimus Health Care, Inc.
6. The patient has the right to have treatment provided with consideration, respect and privacy.
7. The patient has the right to be assessed for pain management and to be treated and/or referred to a specialist.
8. The patient has a right to a second opinion from a physician of his/her choice.
9. The patient has the right to file a grievance requesting resolution of his/her concern. The patient has the right to request changes in processes as it affects the services provided to him/her. The patient has the right to communicate directly with The Joint Commission (www.jointcommission.org), by which Optimus Health Care, Inc. is accredited.

Failure to Keep Appointment Policy

To ensure access to appointments for all patients, Optimus Health Care, Inc. has the following policy regarding patients who frequently fail to keep their appointments:

- If you fail to keep a scheduled appointment or call the office with less than 24 hours' notice to cancel or reschedule an appointment, each such appointment will be considered a "No Show."
- If you miss (3) appointments within a (6) month period, you will be considered to frequently "No Show" for appointments.
- Patients who frequently "No Show" for appointments will be allowed to schedule appointments only during certain designated health center hours.
- This policy applies to medical, dental, pediatrics, behavioral health and OB/GYN patients.
- We will continue to provide you with care during designated health center hours.
- You have the right to appeal Optimus Health Care, Inc.'s determination that you frequently "No Show" to appointments. The health center staff can guide you in beginning the appeal process. A decision will be made within 30 days.