NMPHC Patient Registration and Authorization Form 2019

Patient First Name	Middle (Maiden) Name	Last Name	Name Patient Goes By

Mailing Address ❒ Homeless Street City State Zip **E-Mail Address:**	**Primary Phone**	**Preferences for Messaging:** ❒ Voice Call ❒ Do Not Contact ❒ Text Message ❒ Email
	Sexual Orientation ❒ Lesbian, Gay, or Homosexual ❒ Straight or Heterosexual ❒ Bisexual ❒ Something Else ❒ Don't know ❒ Choose not to disclose	**Gender Identity** ❒ Male ❒ Gender Queer ❒ Female ❒ Other ❒ Transgender Male ❒ Choose not to ❒ Transgender Female Disclose
Date of Birth (*00/00/0000*) / **Social Security Number**	**Marital Status:** ❒ Single ❒ Married ❒ Divorced ❒ Widowed	**How did you hear about us?** ❒ Family/Friends ❒ Advertisement ❒ Website ❒ Social Media ❒ Pharmacy ❒ Staff Member - _____ ❒ Other Health Care Provider _____ ❒ Other - _____
Patient Place of Employment	**Work Phone**	
Race: *Check All That Apply* ❒ Native Hawaiian ❒ Black/African-American ❒ American Indian/Alaska Native ❒ White/Caucasian ❒ Pacific Islander ❒ Asian	**Ethnicity: *Check One*** ❒ Hispanic or Latino ❒ All others	**Are you a Veteran?** ❒ Yes ❒ No **Do you live in public housing?** ❒ Yes ❒ No

If Patient is a Minor

Parent or Guardian's Full Name	Social Security Number	Primary Phone

Mailing Address (City, State, Zip)	Place of Employment and Phone Number

Responsible Party Information for Payment of Services

Full Name	Social Security Number	Date of Birth	Contact Phone Number

Mailing Address	Place of Employment	Work Phone Number

My Emergency Contact Person – (NO RELEASE of Health Information - just Emergency Contact Only)

Full Name	Address (City, State, Zip)	Relationship	Contact Phone Number

Who can we contact about your health for assistance? (Blank means no one – not even a spouse-)

Full Name	Address (City, State, Zip)	Relationship	Contact Phone Number

1. **I have read and acknowledge NMPHC's Privacy Policy regarding my Protected Health Information (PHI) under HIPAA law and understand my contact person above can be contacted as necessary to assist me. I agree with the terms of the policy. I understand that I may retain a copy of the policy by asking for one and I have the right to amend or revoke my PHI.**
2. **I hereby authorize payment of services including the information necessary to process claims. I have submitted all the appropriate cards to be copied for my file (e.g. Medicare, Medicaid, and Insurance).**
3. **I hereby authorize and give permission to NMPHC and its employees to provide such medical, dental and/or behavioral treatment as may be deemed necessary for the patient named above.**

Patient/Guardian Signature _____ Date _____

Sliding Fee Discount Application

Patient Name		Date of Birth	

	Name	Relationship	Amount of Income	Frequency of Income		Office Use Only: Proof Received	Office Use Only: Proof Matches
Head of Household							
Family Member 2							
Family Member 3							
Family Member 4							
Family Member 5							
Family Member 6							
Family Member 7							
Family Member 8							

If your household receives more than 200% of the poverty level/year, check here ❒
[$24,980-1 person] [$33,820-2 people] [$42,660-3 people] [$51,500-4 people]
Add $8,840 per each additional person. **You are NOT required to provide proof of income.**

By my signature, I certify that the information and accompanying documentation I've given about my household and its income is true and complete.

_____

Patient Signature Date

Verifier Initials

I do **not** wish to apply for discounted services/I will not provide proof of my household income.

_____

Patient Signature Date

SUBMIT