COPLIN HEALTH SYSTEMS

Patient Registration Form

PATIENT INFORMATION *

Patient Name: _____ Date of Birth: _____
Address- City: _____ Phone: _____
State/Zip: _____ Email: _____
Cell: _____ Work: _____ Social Security Number: _____ _____ _____

Preferred Phone: Home ☐ Work ☐ Cell ☐
Preferred Method of Contact: Voice ☐ Email ☐ Text ☐ Don't Contact ☐

Preferred Provider: _____ Primary Care Provider: _____

As a Federally Qualified Health Center, we are required to collect the following information.
Coplin Health systems is asking you to self-identify your ethnicity, race, disability, and veteran status. No negative or adverse action will be taken, regardless of whether you provide this information.

Participation in the survey is voluntary. However, your cooperation and participation will allow us to serve our communities better and obtain the most accurate data possible for reporting purposes. No patient will be discriminated against because of race, gender, color, natural origin, age, disability, or religion.

Please select a sexual orientation:
Gender: Female ☐ Male ☐ Transgender Male to Female ☐ Transgender Female to Male
Sexual Orientation: ☐ Straight/heterosexual ☐ Lesbian, Gay, or homosexual ☐ Bisexual ☐ Other

Please select one or more races that you identify with from the following:
☐ Caucasian ☐ Black/African American ☐ Hispanic/Latino ☐ American Indian/Alaskan native
☐ Native Hawaiian/Other Pacific Islander ☐ Asian ☐ American Indian/Alaskan native Other_____

Language: ☐ English ☐ Other (please specify what other language is your primary _____

INCOME INFORMATION – Please complete all that apply. Please Circle the Following:

How many people are currently living in your household? 1 2 3 4 5 6 7 8 9

What is your estimated household monthly net income?
$100–500 $501-$1000 $1001 –$1500 $1501-$2000 $2001-$2500 $2501-$3000
$3001-$3500 $3501-$4000 $4001-$4500 $4501-$5000 $5001-$5500 $5501- $6000

Household Status: Own my home ☐ Rent ☐ Live with someone ☐ In Shelter ☐
Military Status: Not a Veteran ☐ Veteran ☐ Active Service ☐
Disability Status: Do you have a disability as identified by the American with Disabilities Act? Yes ☐ No ☐

PARENT / GUARDIAN INFORMATION

Patient is Minor: Yes ☐ No ☐
Father: _____ (email) _____
Phone (H)_____ (W)_____ (C) _____
Mother: _____Maiden Name: _____ (email) _____
Phone (H)_____ (W)_____ (C) _____
Guardian: _____(email) _____
Phone (H)_____ (W)_____ (C) _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____May we leave a message? __ Y __N
Phone: (Home) _____ (Work) _____ (Cell) _____

Patient Consent to Share Personal Health Information

I, _____, Authorize Coplin Health Systems to share my personal health information with the named persons below. (Please **circle** which information Coplin Health Systems is authorized to share with each named person)

Name: _____ Date of Birth _____ Relationship to Patient: _____
Medical Billing Scheduling Behavioral Health SUDS HIV/AIDS ALL
Name: _____ Date of Birth _____ Relationship to Patient: _____
MedicalBilling Scheduling Behavioral Health SUDS HIV/AIDS ALL
Name: _____ Date of Birth _____ Relationship to Patient: _____
MedicalBilling Scheduling Behavioral Health SUDS HIV/AIDS ALL

Health Information *(Additional health, family & developmental history will be collected visit.)*

Preferred Pharmacy Name: _____
Address_____ Phone Number: _____
Secondary Pharmacy Name: _____
Address_____ Phone Number: _____

CURRENT MEDICATIONS		
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:

ALLERGIES	
Allergen:	Reaction:
Allergen:	Reaction:
Allergen:	Reaction:

Patient/Parent/Guardian Initials: _____

Allergen:	Reaction:
Allergen:	Reaction:

MEDICAL HISTORY List chronic or intermittent disease or health problem(s). Ex: Diabetes, Asthma, High Blood Pressure

_____

_____

SURGERIES List the type and date of the operation (example: tonsils – September 2010)

_____

_____

SERIOUS INJURY OR ACCIDENTS List type of accident and resulting injury and the date (example: broken right leg, 10/08)

_____

_____

INSURANCE INFORMATION – Please complete all that apply. **Please provide a copy of front and back of card.

- ☐ **Primary Health Insurance:** Name of Insured Parent /Guardian: _____
  Date of Birth of Card Holder: _____ SSN of Card Holder: _____
  Address (if different from child: _____
  Place of Employment: _____
  Name of Insurance Company:_____
  ID Number: _____
  Group Number: _____ Effective Date: _____
- ☐ **Secondary Health Insurance**: Name of Insured Parent /Guardian_____
  Date of Birth of Card Holder_____ SSN of Card Holder _____
  Address (if different from child):_____
  Place of Employment _____
  Name of Insurance Company _____
  ID Number _____
  Group Number _____ Effective Date: _____
- ☐ **Dental Insurance**: Name of Insured Parent/Guardian:_____
  Date of Birth of Card Holder_____ SSN of Card Holder _____
  Address (if different from child):_____
  Place of Employment _____
  Name of Insurance Company _____
  ID Number _____
  Group Number _____ Effective Date: _____
- ☐ **No health insurance / Request application for sliding fee**
  - **I would like assistance from Coplin Health Systems to obtain insurance**

HIPAA OF 1996 ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all health care providers and health care facilities to provide patients with a notice describing how an individual's medical information may be used and disclosed as well as how a patient may obtain access to their personal health information. This notice can be found on our website at www.coplinhealth.com or by requesting a copy from Coplin Health Systems' staff. Your signature of this form certifies that you have reviewed the Notice of Privacy Practices. The notice of privacy practices describes the types of uses and disclosures of my protected health information that might occur for my treatment, payment of bills, or in

the performance of Coplin Health Systems' care operational and other purposes that are permitted and required by law. It also describes my rights to access and control of my protected health care information. The Notice of Privacy Practices is also posted in the waiting areas.

Patient Financial Policy

Thank you for choosing ***Coplin Health Systems*** as your health care provider. We appreciate that you have entrusted us with your health care, and we are committed to providing you with the best patient care possible. Your clear understanding of our Patient Financial Policy is important to our provider-patient relationship. Please ask if you any questions about our fees, our policies, or your responsibilities.

1) **Insurance:** Your health insurance policy is a contract between you and your health insurance company. Please note that it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals and/or pre-authorizations. You should be knowledgeable of any deductibles, copayments and/or coinsurance.
   a) We participate in most insurance networks including Medicare and West Virginia Medicaid.
   b) We accept all West Virginia-based insurances at all locations, and Ohio Medicaid at Parkersburg, River Valley, and Southern Local Schools Wellness Center.
   c) Please contact your insurance company with any questions you may have regarding your coverage.
   d) If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
2) **Copayments and Deductibles:** The arrangement to pay copayments and deductibles is part of your contract with your insurance company.
   a) We accept payment by cash, check or credit card.
   b) All copayments must be made at the time of service, unless other arrangements have been made prior to the appointment.
   c) If you have a high deductible policy and know your deductible has not been met, you may pay a deposit towards the deductible at the time services are provided. The deposit amount will be credited to the amount your insurance applies to your annual deductible.
   d) Note: Failure on our part to collect copayments and deductibles from patients may be considered fraudulent. Please help us in upholding the law by paying your copayment at each visit.
3) **Proof of Insurance:** All patients must complete our daily visit slip to update demographic information before being seen. We must obtain a copy of your current insurance card to provide proof of insurance. Failure to provide us with the correct insurance information in a timely manner may result in you being responsible for the balance of the claim.
4) **Insurance Claims Submission:** We will submit your claims (primary and secondary insurances), and assist you in any way we reasonably can to help get your claims paid.
   a) Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.
   b) We will send a statement to you for any balance remaining after your insurance pays.
   c) Please be aware that the balance of your claim is your responsibility if your insurance company denies your claim, and notifies us that it is billable to you.
5) **Uninsured (Self-Pay) Patients:** In order to minimize wait time at check-out, we will collect a deposit for the services provided that day. The deposit is expected to be paid at the time of service.
   a) The deposit for a New Patient visit is $104.
   b) The deposit for an Established Patient visit is $60.
   c) The deposit amount most likely will not cover the total amount of charges for your visit, but will cover a portion. The deposit amount is intended to be a partial payment, not an estimate of the total charges for the visit.
   d) Once all charges are posted to your account, a statement will be sent to you indicating the balance due (total charges minus the deposit amount).

Patient/Parent/Guardian Initials: _____

6) **External Services:** You may be billed separately for diagnostic services, such as laboratory testing, or other specialty services which are not performed by Coplin Health System. For example, laboratory testing performed by Mako Labs.
7) **Payment for Services:** It is your responsibility to make timely payments on your account for the services you receive. If you find that you are unable to pay the balance due in full, please contact us to set up a payment arrangement. We want to work with you to keep your account in good standing, but it is up to you to let us know you need assistance.
8) **Sliding Fee Discount Program:** Coplin Health Systems offers a discounted/sliding fee schedule for patients who do not have insurance or are underinsured (high deductible and/or no secondary insurance). There is an application process for this discount program, and eligibility is based on income and family size. *No one will be denied access to services due to inability to pay*. Please contact any of our clinics for information and an application for the Sliding Fee Discount Program.
9) **Returned Checks:** A $25.00 fee will be charged for all returned checks.
10) **Missed Appointments (No Show):** Missing your scheduled appointment may impact your health. It may also keep another patient from being seen since the appointment time was reserved for you.
    a) A patient is considered a "No Show" when:
        i) The patient does not contact the office to cancel a scheduled appointment within at least two (2) hours prior to the scheduled appointment time
        ii) The patient does not show up for their medical appointment without notifying Coplin Health Systems
    b) Consequences for "No Shows":
        i) New patients will be not be allowed to schedule an appointment if they have "No Showed" for two (2) scheduled appointments for the initial visit. The patient will receive a letter of dismissal from Coplin Health Systems.
        ii) Established patients who "No Show" three (3) times in a calendar year will receive a letter of dismissal from Coplin Health Systems. At the beginning of each year (January 1st) an established patient's "No Shows" will be reset to zero for those patients with two (2) or less "No Shows" the previous year.
    c) The patient, the patient's guardian, or legal representative has the right to appeal the "No Show" status.
    d) A patient who is dismissed due to the "No Show" policy can still be seen for Acute Care services only.

Coplin Health Systems is committed to providing the best treatment for our patients. Our prices are representative of the usual and customary charges for our area. The terms of this financial policy may be amended or updated as needed. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the registration form. I understand the HIPAA acknowledgment, and know how to obtain a copy of the Notice of Privacy Practices. I understand and agree to the Financial Policy. I have accurately and truthfully completed this form to the best of my ability. I understand I am consenting to medical treatment for myself and/or the patient I am responsible for as listed above. I understand that I am financially responsible for any balance. I also authorize Coplin Health Systems or my insurance company to release any information required to process my claims.

_____ _____

Printed Name of Patient or Responsible Party **Printed Patient Name (if Different than Responsible Party)**

_____ _____

Signature of Patient or Responsible Party **Date**

Patient/Parent/Guardian Initials: _____