

PATIENT REGISTRATION

PATIENT INFORMATION

First Name _____ MI _____

Date of Birth (DOB) _____

Last Name _____

Soc Sec # _____

Preferred/Nickname _____

Sex Male Female

Mailing Address _____

Marital Status Single Married Divorced Widowed

City/State/ZIP _____

Employer _____

Local Resort/Motel/Camp _____

Phone _____

Phone _____ Home Cell

Retired Unemployed Other

Phone _____ Home Cell

Preferred Language English Other _____

Email _____

Local Pharmacy Preference _____

EMERGENCY CONTACT

Name/Relationship/Phone # of Emergency Contact

GUARANTOR

For minor patients, name of parent(s) or guardian(s):

Guarantor's Info (Person Responsible for Billing):

Initials _____ D.O.B. _____ SS# _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Company _____

ID # _____

Policy Group # _____ Co-pay \$ _____

SECONDARY INSURANCE

Company _____

ID # _____

Policy Group # _____

DEMOGRAPHIC INFORMATION (OPTIONAL)

For Community Health Center Grant statistics, race/ethnicity, income range, gender identity, and sexual orientation are reporting requirements

RACE (Mark all that apply)

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

FAMILY SIZE _____

- ### INCOME
- \$21,999 or less
 - \$22,000—\$34,999
 - \$35,000—\$49,000
 - \$50,000 or more

SEXUAL ORIENTATION

- Lesbian or gay
- Straight (not lesbian or gay)
- Bisexual
- Something else
- Don't know
- Choose not to disclose

GENDER IDENTITY

- Male
- Female
- Transgender Male (Female-to-Male)
- Transgender Female (Male-to-Female)
- Other
- Choose not to disclose
- Don't know

ETHNICITY

- Hispanic or Latino
- Not Hispanic or Latino

If your income does not qualify for government assistance, you may be eligible for our sliding fee program.

Are you interested?

VETERAN

- Yes
- No

SAWTOOTH MOUNTAIN CLINIC (SMC), INC. CREDIT POLICY

It is the intent of the Sawtooth Mountain Clinic, Inc. that the patient is always responsible for full payment of services rendered. Insurance co-pays are expected at the time of service. Payment may be made by cash, check or credit card.

The staff reminds you that health insurance is a contract between you and your insurance company.

Clinic personnel will cooperate with you in every way to expedite your claims, but it is your ultimate responsibility to see your claims honored. The clinic looks to you, the patient, for payment of its fees. If SMC is provided with current complete insurance information, these claims will be filed directly to your insurance company for you.

For those covered by insurance companies for which SMC is not a contracted provider, all charges are expected to be paid in full at the time of service, unless other arrangements have been made with the Patients Account Representative. If you have filed an insurance claim with your insurance company, you are still subject to collection on past due balances.

Patients whose accounts exceed thirty (30) days without any arrangement or communication will be placed on a pay-as-you-go basis until the account is paid in full. Patients whose accounts are over ninety (90) days may have their account turned over to a collection agency.

The credit policies of SMC enable you to receive medical care and services when you need help and to make arrangements for payment. The essence of our agreement with you is communication. Please keep in contact with us regarding your account.

SAWTOOTH MOUNTAIN CLINIC SLIDING FEE SCALE PROGRAM

The Sliding Fee Scale program is a Federal program that permits Sawtooth Mountain Clinic to reduce the normal costs of medical, dental, mental health, and other services for patients who qualify. All patients are encouraged to apply for the program, whether or not they have insurance and regardless of immigration status. Ask at the Front Desk for more information.

NEW TO MEDICARE POLICY HOLDERS

Are you currently working? NO FULL-TIME PART-TIME

If married, is your spouse working? NO FULL-TIME PART-TIME

If no, indicate retirement date: Yourself _____ Spouse _____

If I am signing as Authorized Representative of the patient, I am: [] Court appointed guardian/custodian [] Other _____

Signature (Patient or Authorized Representative)

Date

Witness (signature by mark must be witnessed)