Sawtooth Mountain Clinic
Together Through Life
a 501©(3) not-for-profit organization

PATIENT REGISTRATION

PATIENT INFORMATION

First Name ____ MI _______

Last Name ____

Preferred/Nickname________________________________

Mailing Address ____

City/State/ZIP ____

Local Resort/Motel/Camp____________________________

Phone ____ [ ] Home [ ] Cell

Phone ____ [ ] Home [ ] Cell

Email ____

Date of Birth (DOB) ____

Soc Sec # ____

Sex [ ] Male [ ] Female

Marital Status [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Employer ____

Phone ____

[ ] Retired [ ] Unemployed [ ] Other

Preferred Language [ ] English [ ] Other ____________________

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

ETHNICITY
- [ ] Hispanic or Latino
- [ ] Not Hispanic or Latino

VETERAN
- [ ] Yes
- [ ] No

FAMILY SIZE _______

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

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

Are you interested?

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

PRONOUN PREFERENCE
- [ ] He/Him
- [ ] She/Her
- [ ] Other _________________

GENDER IDENTITY
- [ ] Male
- [ ] Female
- [ ] Transgender Male (Female-to-Male)
- [ ] Transgender Female (Male-to-Female)
- [ ] Other
- [ ] Choose not to disclose
- [ ] Don't know

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.

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)