Patient Registration

Social Security: Birth Date: Sex:

First Name: Mid. Initial: Last Name:

Home Address: Apt/Suite #

City: State: Zip Code:

Email (13 and older): _____

Home Phone #: Cell Phone #: Work Phone #:

Preferred Phone: ☐ Home ☐ Work ☐ Cell Please communicate by: ☐ Phone ☐ E-mail ☐ Text

Race:

☐ Asian ☐ American Indian ☐ White ☐ Other

☐ Black/African American ☐ More than one race

Ethnicity:

☐ Latino/Hispanic ☐ Not Latino/Hispanic ☐ Other ☐ Refused

Preferred Language:

☐ English ☐ Spanish ☐ Creole ☐ Sign Language ☐ Other:

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Employment Status:

☐ Unemployed ☐ Employed ☐ Self-Employed ☐ Disabled ☐ Retired

☐ PT Student ☐ FT Student

As a Federally Qualified Health Center we are required to ask the following questions:

(The following questions are not required for patients less than 18 years of age)

Gender Identity: ☐ Male ☐ Female ☐ Choose not to disclose ☐ Other

☐ Transgender Male/Female to Male ☐ Transgender Female/Male to Female

Sexual Orientation: ☐ Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Other

☐ Decline

Approximate Monthly Income (before taxes): _____ Number of people supported in the household: _____

Are you a Military Veteran? ☐ Yes ☐ No Are you Homeless? ☐ Yes ☐ No

Do you live in Section 8 Public Housing? ☐ Yes ☐ No

Referred to us by: ☐ TV ☐ Social Media ☐ Radio ☐ Relative ☐ Event ☐ Friend ☐ Hospital ☐ Insurance ☐ Other:

Preferred Pharmacy : _____ City: _____ Phone Number: _____

EMERGENCY CONTACT

Name: _____ Phone Number: _____ Relationship: _____

INSURANCE INFORMATION

Are you covered by insurance? ☐ YES ☐ No If yes, please indicate primary insurance: _____

Subscriber's name: _____ Birth Date: _____ Relationship to subscriber: _____

Member ID: _____ Group Number: _____

Parent/Legal Guardian Information (Complete ONLY if patient is a minor)

Parent's Name: _____ Phone Number: _____

Date of Birth: _____

Parent's Name: _____ Phone Number: _____

Date of Birth: _____

Other: _____ Phone Number: _____

Date of Birth: _____ Relationship: _____

Print Name: _____ Signature: _____

Relationship: _____ Date: _____

Please return this document to the front desk staff

TREATMENT/PAYMENT AUTHORIZATION FOR TREASURE COAST COMMUNITY HEALTH CENTERS, INC (TCCH)

**Please initial next to each line to show that you have read and consent to each statement

1. _____ I give consent and request TCCH to provide me and/or my family with health care**. I acknowledge my responsibility to pay for that care according to the fees established. I have informed TCCH of all insurance coverage and have provided copy of all insurance cards. I understand that I am responsible for all charges and fees for my care, except any that are covered by insurance accepted by TCCH. I understand that payment, including co-insurance, co-pays and self-pay/sliding fee payments, is due at the time of service.

2. _____ HEALTH CARE RELEASE–I give consent for release of routine medical record information for the purposes of reimbursement, arranging referrals or other health care. I also allow TCCH to release immunizations records to any school or day care.

3. _____ I give permission for my Protected Health Information (PHI) to be disclosed for the purpose of coordinating health care needs, communicating results, and care decisions to the friends and/or family members listed below (*Initial if applicable*)

Name	Relationship	Contact Number

4. _____ I give permission for the individuals listed below to accompany my minor child_____(Child's Name) to TCCH. This will allow TCCH to treat the child, discuss the minor's care and PHI, such as treatment plans, appointments, etc. (*Initial if applicable*)

Name	Relationship to Patient	Contact Number

5. _____ CARE COORDINATION – I give consent for coordination of my health care with home and community-based providers of clinical services to also include the chronic care management program.

6. _____ ACCESS – I give my consent to access my history from other places (e.g. Pharmacies, Lab Vendors, Accountable Care Organizations), electronically for the purpose of my health care.

7. _____ PATIENT PORTAL – I have the opportunity to gain 24 hour access to the Patient Portal. I will keep my sign-on and password safe and access only the accounts I have the right to look at.

8. _____TEXT/EMAIL – I give my consent to receive appointment reminders and other healthcare communications/information from TCCH

9. _____I hereby grant permission to TCCH to use photographs of me or my child taken on _____ at TCCH for identity purposes ONLY."

10. _____ I HAVE BEEN OFFERED AND/OR RECEIVED THE NOTICE OF PRIVACY PRACTICE

THIS CONSENT WILL STAY IN EFFECT FOR TWELVE (12) MONTHS FROM THE DATE SIGNED.

You have the right to amend or revoke this consent at any time.

Signature of: _____

(Circle One) ☐Patient ☐Parent ☐Guardian Date

TCCH Staff Member: _____Date: _____

**Health Care – Medical, Dental and/or Behavioral Health