DISCLAIMER: As a Federally Qualified Health Center (FQHC), we are required to request the information below. We realize that this is very personal Information. Therefore, we want you to know your answers will be held in the strictest confidence. The information collected is used only as a total from our database, so it in no way identifies a specific individual or family. The information collected helps to shape future programs and services to be made available at our clinics as well as on local, state, and federal levels. Thank you for your participation.

NORTHWEST HEALTH SERVICES

Fill out this form to register as a Northwest Health Services' patient.

Today's Date:	**Northwest Health Care Provider:**

Patient Information (Please Print)

Last Name:	First Name:	Middle:	Suffix: ☐ Jr. ☐ Sr. ☐ Other

Former Name:	Preferred Name:	SS#:	Birthdate: / /	Sex Assigned at Birth: ☐ Male ☐ Female

Billing Street Address	City:	State:	Zip Code:	Country:	County:
Home Address (if different):	City:	State:	Zip Code:	Country:	County:

Home Phone:	Work Phone:	Cell Phone:

Email Address:

Gender Identity:
- ☐ Female
- ☐ Male
- ☐ Female-to-Male (FTM) *Transgender Male*
- ☐ Male-to-Female (MTF) *Transgender Female*
- ☐ Choose Not to Disclose
- ☐ Other

Sexual Orientation:
- ☐ Lesbian or Gay
- ☐ Heterosexual (Straight)
- ☐ Bisexual
- ☐ Something Else
- ☐ Don't Know
- ☐ Chose Not to Disclose
- ☐ Unknown

Marital Status:
- ☐ Divorced
- ☐ Legally Separated
- ☐ Life Partner
- ☐ Married
- ☐ Single
- ☐ Widowed
- ☐ Declined to Specify

Student Status:
- ☐ Full Time
- ☐ Not a Student
- ☐ Part Time

Patient Notification: *(Mark all that apply)*
- ☐ Email
- ☐ Phone Call
- ☐ Text Message
- ☐ Patient Portal

Race: *(Check all that apply)*
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Other
- ☐ White
- ☐ Declined to Report

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ Unknown
- ☐ Declined to Report

Preferred Language:
- ☐ English
- ☐ Spanish
- ☐ French
- ☐ German
- ☐ Japanese
- ☐ Italian
- ☐ Sudanese
- ☐ Burmese
- ☐ Tigrinya
- ☐ Declined to Answer
- ☐ Other_____

Contact Preference:
- ☐ Cell Phone
- ☐ Home Phone
- ☐ Work Phone
- ☐ Don't Call Home
- ☐ Don't Call Work
- ☐ Don't Leave Message
- ☐ Okay to Leave Message

Patient Outreach: *(Mark all that apply)*
- ☐ Text
- ☐ Email
- ☐ Patient Portal

How did you hear about us?
- ☐ Billboard
- ☐ Google
- ☐ Facebook/Instagram
- ☐ TV Commercial
- ☐ Radio
- ☐ Word of Mouth/Community Outreach
- ☐ Other:_____

Patient Name: _____ D.O.B. _____

PERSON RESPONSIBLE FOR BILL						
Last Name:	First Name:	Middle Name:	Previous Last Name:			
SS#:	Birthdate: / /	Relationship: ☐ Self ☐ Parent ☐ Life Partner ☐ Spouse ☐ Other				
Street Address:	City:	State:	Zip Code:	Country:	County:	
Home Phone:	Work Phone:	Cell Phone:				

EMPLOYER INFORMATION					
Employer Name:					
Employer Street Address:	City:	State:	Zip Code:	Country:	County:
Occupation:	Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Active Duty ☐ Retired ☐ Self Employed	Work Phone:	Retirement Date: / /		

EMERGENCY CONTACT / NEXT OF KIN				
Last Name:	First Name:	Relationship:	Phone Number:	
Street Address:	City:	State:	Zip Code:	

INSURANCE INFORMATION: Card MUST be given to front desk representative		
Primary Insurance: ☐ Medicare ☐ Medicaid ☐ BCBS ☐ United Healthcare ☐ Other _____		
Name of Policy Holder:	Birthdate of Policy Holder:	Relationship:
Secondary Insurance: ☐ Medicare ☐ Medicaid ☐ BCBS ☐ United Healthcare ☐ Other _____		
Name of Policy Holder:	Birthdate of Policy Holder:	Relationship:

Patient Name: _____- D.O.B. _____

HOUSING & WORKER STATUS		
Homeless Status: ☐ Doubling Up ☐ Street ☐ Not Homeless ☐ Transitional ☐ Shelter ☐ Unknown	Migrant Worker Status: ☐ Migrant ☐ Not a Farm Worker ☐ Seasonal Worker	Have you ever served in the armed forces: ☐ No ☐ Yes

INCOME TABLE					
Family Size					
1	☐ $0 - $13,590	☐ $13,591 - $16.988	☐ $16,989 - $20,385	☐ $20,386 - $27,180	☐ $27,181+
2	☐ $0 - $18,310	☐ $18,311 - $22,888	☐ $22,889- $27,465	☐ $27,466 - $36,620	☐ $36,621+
3	☐ $0 - $23,030	☐ $23,031 - $28,788	☐ $28,789 - $34,545	☐ $34,546 - $46,060	☐ $46,061+
4	☐ $0 – $27,750	☐ $27,751 - $34,688	☐ $34,689 - $41,625	☐ $41,626 - $55,500	☐ $55,501+
5	☐ $0 - $32,470	☐ $32,471- $40,588	☐ $40,589 - $48,705	☐ $48,706- $64,940	☐ $64,941+
6	☐ $0 - $37,190	☐ $37,191 - $46,488	☐ $46,489 - $55,785	☐ $55,786 - $74,380	☐ $74,381+
7	☐ $0 - $41,910	☐ $41,911 - $52,388	☐ $52,389 - $62,865	☐ $62,866 - $83,820	☐ $83,821+
8	☐ $0 - $46,630	☐ $46,631- $58,288	☐ $58,289 - $69,945	☐ $69,946- $93,260	☐ $93,261+

READ AND SIGN THIS SECTION

I, the patient or parent/guardian of this patient have the legal responsibility and the right to obtain treatment and further:

- Understand this consent is good for one year from the date indicated below.
- Allow the health care provider to give the treatment needed. This care may include but is not limited to:
    - Radiology to diagnose a problem
    - Taking samples of blood which may look for contagious diseases such as Hepatitis and HIV/AIDS
    - Taking samples of body fluids or body tissue
    - Giving medicine, immunizations and vaccines
    - Dental services
    - Behavioral health services
- Allow my provider to treat in emergencies if it may save my/this patient's life or health.
- Agree that care at NHS emphasizes care coordination and communication into what we, as a team, deem best for the patient.
- Understand that I have the right to refuse any recommended treatments that I do not agree with,

INSURANCE & PAYMENT

- Understand that copay/payment in full is due at the time of service.
- If patient copay and/or outstanding balance cannot be paid at time of service, and the nature of the visit is a non-emergency as determined by NHS triage policy, the appointment may be re-scheduled.
- Understand that NHS offers the uninsured discount program for those that are self-pay and do not qualify for NHS's Sliding Fee Discount Program. To receive the uninsured discount program:
    - A payment of $100 is required at time of service.
    - A 20% discount will be applied to the total charges and
    - The remaining balance will be billed to the patient and is due upon receipt.
- Understand NHS will assess a fee for returned checks. After two returned checks, cash or debit/credit card will be the only acceptable means of payment.
- Understand NHS accepts Medicare, Medicaid, and most major commercial insurances.
- Authorize Northwest Health Services, Inc. (NHS) to release to Medicare/Medicaid/Insurance, the private health information necessary to process my/this patient's claim(s).
- Agree that NHS will file claim and complete the steps to collect insurance payment.
- Authorize Medicare/Medicaid/Insurance payment to be paid directly to NHS.
- Agree that if Medicare/Medicaid/Insurance doesn't pay the claim in full, I am responsible for any remaining balance.

Sign: _____ Date: _____

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us. All complaints must be given in writing on the form provided by NHS. To obtain a form, contact the Director of Compliance at (816) 271-8227. You also may file a complaint with the U. S. Department of Health and Human Services Office for Civil Rights. ***You will not be penalized for filing a complaint.***

WHO CAN HAVE YOUR HEALTH INFORMATION?

Please fill out this form. It will tell us which family members and friends have your permission to have your health information.

Patient Name:	Date of Birth:

ABOUT THIS FORM:

- Let's those listed below have information about your medical care or payment
- Informs those listed below of your location, health or death.

THESE PEOPLE CAN HAVE MY HEALTH INFORMATION:

1. Name:		Relationship to you:	
Phone Number:	Street Address:		
City:		State:	Zip Code:
2. Name:		Relationship to you:	
Phone Number:	Street Address:		
City:		State:	Zip Code:
3. Name:		Relationship to you:	
Phone Number:	Street Address:		
City:		State:	Zip Code:

PLEASE SIGN HERE:

By signing below, I allow Northwest Health Services to talk about or release my health information with the people listed above. **Mark all that you approve:**

☐ All Information

☐ Billing Information ☐ Appointment Information ☐ Lab Results ☐ HIV Testing Results ☐ Treatment(s)

☐ Behavioral Health Services ☐ Substance Abuse ☐ Dental Services

☐ Other_____

Patient/Guardian Signature:	Today's Date

Your permission expires in one year unless cancelled in writing.