SVT Health&Wellness *Partnering in the Journey!*

Patient Information & Registration

Please let us know if you have questions filling out this form. We're happy to help!

PREFERRED CARE PROVIDER:	PREFERRED PHARMACY:	TODAY'S DATE:	
NAME (Last):	(First):	(M.I.):	PREFERRED NAME:
DATE OF BIRTH:	SOCIAL SECURITY NUMBER:	Do you need an interpreter? ☐ Yes / ☐ No PRIMARY LANGUAGE: _____	

*RACE (Check all that apply) ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Pacific Islander ☐ Other
☐ American Indian/Alaska Native (see #6 on back of this form) *Are you Hispanic or Latino? ☐ Yes / ☐ No

PHYSICAL ADDRESS (Address, City, State, Zip):	MAILING ADDRESS (if different from physical address):
PRIMARY CONTACT PHONE NUMBER: Message OK? ☐Yes ☐No _____ Type (check one) ☐ Cell ☐ Home ☐ Work	EMAIL ADDRESS: _____ You will receive an email invitation to access your medical record through the secure Patient Portal.

*LIVING ARRANGEMENT ☐ Own/Rent Home ☐ Homeless ☐ Live with friends/family ☐ Public Housing

*AGRICULTURAL EMPLOYMENT STATUS:
1. Have you migrated to our area from another community to work in agriculture? ☐ Yes ☐ No
2. Are you employed as an agricultural worker on a seasonal basis only (not permanently)? ☐ Yes ☐ No

*NUMBER OF PEOPLE IN HOUSEHOLD:	*ESTIMATED HOUSEHOLD INCOME (before tax) $_____ per ☐ Month ☐ Year (check one)	*VETERAN ☐ Yes ☐ No

Would you like to apply for our **Discount Program?**: ☐ No or ☐ Yes

*SEXUAL ORIENTATION: ☐ Straight or Heterosexual ☐ Lesbian, Gay, or Homosexual ☐ Bisexual ☐ Other, please specify: _____ ☐ Don't Know ☐ Choose not to Disclose	*GENDER IDENTITY: ☐ Male ☐ Female ☐ Transgender male/Trans man/Female-to-male ☐ Transgender female/Trans woman/Male-to-female ☐ Other, please specify: ☐ Choose not to disclose

PLEASE LIST ALL MEMBERS OF YOUR HOUSHOLD

NAME	Relationship	Age	Date of Birth	Social Security Number

EMERGENCY CONTACT

NAME (First)	(Last)	DATE OF BIRTH	RELATIONSHIP TO PATIENT
PHONE (Home)	(Message/Work)		(Cell)

*SVTHW is required to collect this information as part of our grant requirements.

STAFF USE ONLY: Patient Sliding Fee Discount Level: _____% Effective Date: _____
Applied to patient #'s:_____
Communicated to Patient?: ❒ Yes, on (Date)_____ ❒ No, Letter Sent on: _____

INSURANCE INFORMATION & STATEMENT OF FINANCIAL RESPONSIBILITY

1. I authorize release of any information necessary to process my insurance claims and assign and request payment directly to SVT Health & Wellness (SVTHW). I understand that SVTHW will bill my insurance as a service to me; however, I am ultimately responsible for co-payments, deductible payments, and all charges for services not covered by my insurance plan at the time of service

Please Complete - Primary Insurance	**Please Complete - Secondary Insurance**
Insurance Company Name:	Insurance Company Name:
ID:	ID:
Group/Policy #:	Group/Policy #:
Subscriber's Name:	Subscriber's Name:
Subscriber's Phone #:	Subscriber's Phone #:
Subscriber's Employer:	Subscriber's Employer:
Subscriber's SS#:	Subscriber's SS#:
Subscriber's Date of Birth:	Subscriber's Date of Birth:

2. I understand that I may revoke this consent at any time in writing to the office.

3. I am being seen for a **work-related injury**:

Insurance Carrier Name:		Claim Number:	
Address:		Employed at:	
City, State, Zip:		Date of Injury:	
Phone Number:		Time of Injury:	

4. I agree that I am responsible for payment of all products or services rendered to me, or the patient for which I am the guarantor of payment, in accordance with the regular rates and terms of SVTHW.

5. I understand that SVTHW will make all reasonable attempts to collect amounts due and failure to adhere to payment agreements or financial responsibility may result in:
   a. My account being sent to a collections agency or attorney, with applicable fees (including attorney's fees and/or collections expense) assessed. All delinquent accounts may bear interest at the legal rate.
   b. Full payment will be expected prior to all future visits.
   c. Denial of non-emergent appointments.

6. Should I qualify for American Indian/Alaskan Native beneficiary benefits, I understand that the Indian Health Service (IHS):
   a. is the payer of last resort. All other insurance (Medicare, Medicaid, private insurance) must be billed first.
   b. will NOT pay for office visits/labs/dental/radiology services at another facility without a referral from an SVTHW provider before the services are performed, unless it is a life-or-limb emergency.
   c. requires that I present a copy of my Tribal Enrollment card, copy of my Certificate of Indian Blood/BIA Card, Photo ID (driver's license or passport), income and household information, and for infants a copy of Birth Certificate (if available).
   d. I will be contacted annually to update this information.

7. I have read the above information and have no further questions. The income and household information provided by me is true to the best of my knowledge. Should I qualify for a Sliding Fee Discount, I understand that I will be asked to update my income and household information at least annually, and may be subject to proof of documentation requests.

_____ _____

PRINT Patient Name — Patient's Date of Birth

_____ _____

Patient/Guarantor Signature — Date Signed

If not signed by Patient:

_____ _____ _____ _____

PRINT Guarantor's Name — Relationship to Patient — Guarantor SSN — Guarantor DOB

CONSENTS & AUTHORIZATIONS

APPOINTMENT POLICY

Initial _____	Appointment times are reserved exclusively for me. Failure to appear at my appointment on time may result in delay of future appointments. CANCELLATIONS: I will notify the clinic at least 24 hours in advance if I cannot make my appointment. I will notify the clinic if I am running late so they may adjust their schedules. CHILDREN: I understand that a parent/guardian must accompany children at every medical, wellness or dental appointment. A parent/guardian must stay in exam area or waiting room throughout the appointment to answer any questions or provide authorizations of care. If child is not to be accompanied by parent, I will ask for a "*Guardianship of Minor*" form to complete. I agree to the above terms of this Appointment Policy and I have received a copy of the Patient Rights & Responsibilities.

CONSENT FOR EVALUATION AND/OR TREATMENT AND TO USE & DISCLOSE HEALTH INFORMATION

Initial _____	I authorize SVT Health & Wellness (SVTHW) to provide evaluation and treatment services to me (or patient, if legal representative). I agree to participate in my treatment planning process to the best of my ability and will let my provider know if situations occur that prevent me from participating in treatment. I understand this consent will remain valid as long as I receive treatment at SVTHW. I understand that all of the information gathered in the course of my treatment is confidential. However, confidential information may be disclosed without my consent in accordance with state and federal law.

E-PRESCRIBING CONSENT

Initial _____	SVTHW has implemented electronic prescribing (also known as e-prescribing) for its patients. E-prescribing involves the ability to send prescriptions electronically to pharmacies. By signing this Consent Form, I (the Patient or Patient's Legal Representative) am agreeing that SVTHW can request and use the prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

PRESCRIBING OF CONTROLLED MEDICATIONS

Initial _____	By signing this Consent Form, I (the patient or patient's legal representative) am hereby notified that: ○ SVTHW does not provide prescriptions for long term use of pain medications and other controlled drugs. ○ Providers will first explore and recommend non-narcotic methods of pain control, including non-narcotic prescriptions, massage, acupuncture, exercise and cognitive behavioral therapy as a means of effectively addressing ongoing pain. ○ Any prescriptions for narcotic pain medications will be limited to the minimal time (3 days) required to treat acute pain. ○ SVTHW does not refill controlled prescriptions that are lost or stolen. ○ SVTHW does not refill controlled prescriptions written by other providers outside of SVTHW. ○ SVTHW providers are required to check a statewide and national prescription database for patient's prescription history for current and past prescription patterns prior to writing a prescription for controlled medications.

NOTICE OF PRIVACY PRACTICES

Initial _____	I acknowledge and agree that I have reviewed a copy of the SVTHW Notice of Privacy Practices made available to me. I acknowledge that I may request a copy of the notice at any time.

TEXT MESSAGING SERVICES AUTHORIZATION

SVT Health & Wellness (SVTHW) will send notifications to our patients, such as appointment reminders, using electronic communication through our Electronic Health Record (EHR) system. **There is some level of risk that information in a text message could be read by someone besides you. Please let us know if you would like us to communicate with you by text message:**

CIRCLE Preferences:

Text Messaging	Yes	Please communicate with me by text message. I will let you know right away if my cell phone number changes.
	No	DO NOT communicate with me by text message.

DISCLOSURES TO FAMILY MEMBERS & FRIENDS

Disclosures related to the patient's presence, location, or health condition at SVTHW may be made to family and friends, or as needed for payment of health care services. We will only disclose information relevant to Patient's current treatment.

☐ **DO NOT DISCLOSE TO ANYONE**

I provide my consent to allow SVTHW to disclose my presence, location and health care information to:

Print Name	Phone Number	Relationship to Patient
Print Name	Phone Number	Relationship to Patient

I (the Patient or Patient's Legal Representative) hereby provide my signature below to give my consent to SVT Health & Wellness (SVTHW) and its Partners/Business Associates to release my medical and/or behavioral health-related information according to the provisions and limitations indicated above. I have the right to review the Notice of Privacy Practices prior to signing this consent. I have the right to request that SVTHW restrict how it uses or discloses my Personal Health Information (PHI) to carry out treatment, payment and health care operations (TPO). SVTHW is not required to agree to my requested restrictions, but if it does, it is bound by the agreements. I am also aware that I may revoke my consent by submitting a written request to SVTHW at any time, except to the extent that SVTHW has already made disclosures in reliance upon my prior consent. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient or Legal Guardian/Representative's Signature

PRINT Patient Name	Patient's Date of Birth	Date Signed

If <u>not</u> signed by Patient:

PRINT Patient or Legal Guardian/Representative's Name	Relationship to Patient