Chart #_____

SALINA FAMILY HEALTHCARE CENTER

PATIENT REGISTRATION FORM

Information helps us care for you and is handled in a private and confidential manner. Blanks considered "declines comment".

Legal Name:			
Preferred Name:			
Legal Sex: ☐M ☐F			
The legal name and sex on your insurance must be used on all insurance, billing, and corresponding documents.			
Date of Birth:		Social Security #:	
Your answers to the following questions will help us reach you quickly and discreetly with important information.			
Home Phone:	Cell Phone:	Work Phone:	Best number to use: ☐Home ☐Cell ☐Work
Street Address:		City:	State: Zip:
Is this public housing? ☐Yes ☐No			
Billing Address: (if different than above):		City:	State: Zip:
Email Address:		Preferred Method of contact: ☐Phone ☐Email ☐Letter ☐Text	
Occupation:		Employer/School Name:	
Emergency Contact's Name:	Phone Number:	Relationship to you:	

PERMISSION TO RELEASE INFORMATION: List people we may release information about your healthcare to.
(New list is required each time form is completed. Consent remains in effect until new list is provided or revoked in writing.)

☐**Emergency Contact** ☐**No one else**		
1)	Phone #:( )	
2)	Phone #:( )	
3)	Phone #:( )	
Legal Parent/Guardian #1 Name:	Phone #:	Relationship:
Legal Parent/Guardian #2 Name:	Phone #:	Relationship:
Primary Caregiver (if not Parent/Guardian):	Phone #:	Relationship:

Notarized Treatment Authorization for Minor form REQUIRED if you are not Legal Parent/Guardian. See front desk for form.

INSURANCE INFORMATION

Fill out ALL the following information regarding your health insurance. (GIVE YOUR INSURANCE CARDS TO RECEPTIONIST.)

Primary Medical Insurance Name:	**ID#**	**Group#**
Secondary Medical Insurance Name:	**ID#**	**Group#**
Primary Dental Insurance Name:	**ID#**	**Group#**
Secondary Dental Insurance Name:	**ID#**	**Group#**
Vision Insurance Name:	**ID#**	**Group#**

The following information is for demographic purposes and will not affect your access to care or the quality of care you receive.

Race	**Ethnicity**	**Preferred Language**	
☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian ☐ American Indian/Alaskan Native ☐ Pacific Islander ☐ Other	☐ Hispanic/Latino ☐ Not Hispanic/Latino **Veteran** ☐ Veteran ☐ Not a Veteran	☐ English ☐ Spanish ☐ Vietnamese ☐ Sign Language ☐ Other (please specify) _____	

Have you been homeless at any time in this calender year? ☐ Yes ☐ No

Are you a seasonal or migrant farmworker? ☐ Yes ☐ No

Do you have an advance directive (living will or DNR)? ☐ Yes ☐ No If yes, please give a copy to the front desk

Household Size and Income (Under the number of people in your household, check the range of income that pertains to you):

1 Person	**2 People**	**3 People**	**4 People**
☐ $ 0 - $ 15,650	☐ $ 0 - $ 21,150	☐ $ 0 - $ 26,650	☐ $ 0 - $ 32,150
☐ $ 15,651 - $ 20,971	☐ $ 21,151 - $ 28,341	☐ $ 26,651 - $35,711	☐ $ 32,151 - $43,081
☐ $ 20,972 - $ 26,136	☐ $ 28,342 - $ 35,321	☐ $ 35,712 - $ 44,506	☐ $ 43,082 - $53,691
☐ $ 26,137- $ 31,300	☐ $ 35,322 - $ 42,300	☐ $ 44,507- $ 53,300	☐ $ 53,692 - $64,300
☐ Over $ 31,301	☐ Over $ 42,301	☐ Over $ 53,301	☐ Over $ 64,301
5 People	**6 People**	**7 People**	**8 People**
☐ $ 0 - $ 37,650	☐ $ 0 - $ 43,150	☐ $ 0 - $ 48,650	☐ $ 0 - $ 54,150
☐ $ 37,651- $ 50,451	☐ $ 43,151 - $ 57,821	☐ $ 48,651 - $ 65,191	☐ $ 54,151 - $ 72,561
☐ $ 50,452 - $ 62,876	☐ $ 57,822 - $ 72,061	☐ $ 65,192- $ 81,246	☐ $ 72,562 - $ 90,431
☐ $ 62,877 - $ 75,300	☐ $ 72,062 - $ 86,300	☐ $ 81,247 - $ 97,300	☐ $ 90,432 - $ 108,300
☐ Over $ 75,301	☐ Over $ 86,301	☐ Over $ 97,301	☐ Over $ 108,301

Please list name and specialty of providers you see outside of Salina Family Healthcare Center (ex: OB/GYN, GI, Cardiologist, Therapist, etc.):

Name of Doctor/Clinic	**Type of Doctor/Clinic**
1)	1)
2)	2)
3)	3)
4)	4)

Patient/Legal Guardian Signature:	**Today's Date:**

For Office Use Only
Form Processed by:_____

SALINA FAMILY HEALTHCARE CENTER

Chart #: _____

NEW & ANNUAL PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

Legal Name:	DOB:

Assignment of Benefits and Authorization to Release Medical Information:
I request that payment of authorized benefits from Medicare, Medicaid, and/or any insurance carrier applicable, be made to me, or on my behalf, to Salina Family Healthcare Center, for any services, including, but not limited to, telemedicine and/or teledentistry, furnished to me and/or my dependent family members by my provider. I authorize any holder of medical/dental/vision information about me and/or my family members to release it to the Department of Children and Families, the Centers for Medicare and Medicaid Services (CMS), applicable insurer(s), and/or agent of these companies, and/or the listed responsible person(s), and information needed to determine these benefits or the benefits for other related services.

Immunization Consent:
I give consent for my child to receive all immunizations recommended by the Center for Disease Control. I understand that this clinic follows the Center for Disease Control's guidelines for schedules, doses, and particular vaccines in administering these immunizations. I understand that this consent is applicable if I am filling out this form on behalf of a minor child.

Financial Account Policy:
By my signature below, I am agreeing to the Financial Account policies set forth by Salina Family Healthcare Center. A detailed description of the Financial Account Policy is available for all patients, upon request.

Disclosure of Insurance Coverage:
I have also disclosed all insurance coverage in effect at the time services were provided to me. I understand that failure to inform Salina Family Healthcare Center of any third party insurance coverage will be considered fraud and I understand that the clinic will prosecute to the fullest extent of the law.

Acknowledgement of Services:
By signing below, I acknowledge that Salina Family Healthcare Center provides an integrated care model where behavioral health screenings and consults will be part of the patient-centered care provided.

Patient and Center Rights and Responsibilities:
I acknowledge that I have received a copy of Salina Family Healthcare Center's Patient and Center Rights and Responsibilities form. We ask you acknowledge your receipt of this document by signing below. You should keep a copy of the Center's Patient and Center Rights and Responsibilities; however, if you wish to receive another copy you may request a copy at any time. The most current copy of Center's Patient and Center
Rights and Responsibilities will be posted in our office. I acknowledge that I received a copy of Center's Patient and Center Rights and Responsibilities effective October 17, 2024.

Notice of Privacy Practices
Maintaining privacy of your health information is very important to us. You have been offered our Notice of Privacy Practices. We ask you acknowledge your receipt of this Notice by signing below. You should keep a copy of the Notice; however, if you wish to receive another copy you may request a copy at any time. The most current copy of this Notice will be posted in our office as well as the website. I acknowledge that I was offered a copy of Center's Notice of Privacy Practices effective April 17, 2025.

Televideo visits
I consent to telemedicine visits, including medical, behavioral health, dental, pharmacy, eye care, and nursing visits. I agree to use the video-conferencing platform for virtual sessions. *All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. All existing confidentiality protections under federal and Kansas state law apply to information disclosed during this telemedicine consultation/appointment. You may withhold or withdraw consent to the telemedicine consultation or appointment at any time without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. Video, audio, and/or photo recordings may be taken during the consultation, appointment, or service.

Patient/Legal Guardian Signature: **Today's Date:**

For Office Use Only
Form Processed by: _____

Patient Name: _____

DOB: _____

Social Determinants of Health (SDOH) Questionnaire

The purpose of this questionnaire is to better understand circumstances of daily life that may impact your health. Please mark the answer(s) that are the truest for you in the left column.

(Q7) What is your housing situation today?

	I have housing
	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
	I choose not to answer this question

(Q8) Are you worried about losing your housing?

	Yes
	No
	I choose not to answer this question

(Q14) In the past year, have you or any family members you live with been *unable* to get any of the following when it was *really needed*? Check all that apply.

YES	NO	
		Food
		Utilities
		Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)
		Phone
		Clothing
		Childcare
		Other (please write):
		I choose not to answer this question

(Q15) Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

	Yes, it has kept me from medical appointments or from getting my medications
	Yes, it has kept me from non-medical meetings, appointments, work or from getting things that I need
	No
	I choose not to answer this question

(Q17) Stress is when someone feels tense, nervous, anxious or can't sleep at night because their mind is troubled. How stressed are you?

	Not at all
	A little bit
	Somewhat
	Quite a bit
	Very much
	I choose not to answer this question
	Does not apply

(Q20) Do you feel physically and emotionally safe where you currently live?

	Yes
	No
	Unsure
	I choose not to answer
	Does not apply

(Q21) In the past year, have you been afraid of your partner or ex-partner?

	Yes
	No
	Unsure
	I choose not to answer
	Does not apply

If you identified any of the above concerns, please tell us if it is ok to contact you with information about available resources.

- ☐ I am ok with printed resources by mail
- ☐ I am ok with a phone call or visit with a care coordinator or behaviorist, if indicated
- ☐ I decline additional services

Entered By: (*Office Use Only)*

_____

Patient Signature: _____

Date: _____

☐ **Filled out by parent/guardian**

***If this Questionnaire is not filled out, this will be considered a negative screening.**

The Social Determinants of Health Questionnaire has utilized content from the PRAPARE® screening tool.