HUNTER HEALTH

Health Record #
(For office use only)

Hunter Health
Patient Registration Form

PATIENT INFORMATION

*Legal Name:
_____
Last First Middle Preferred Name

**Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name is different from these, please let us know.*

Social Security #:	Birth Date:	Are you a Veteran: ☐ Yes ☐ No	Service Branch:
Street Address:		Po Box:	

City	State	Zip Code	Home Phone:	Cell Phone:
Occupation: _____ ☐ Full Time ☐ Part Time		Employer:		Work Phone:

Demographic Information:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Preferred Language: ☐ English ☐ Spanish ☐ Vietnamese Other:_____ | Do you need a translator:

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown

Race: ☐ American Indian/ Alaska Native ☐ Asian ☐ Black or African American
Tribe:_____
☐ Filipino ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other_____

Assigned Sex at Birth:
☐ Male ☐ Female ☐ Choose Not to Disclose

* I currently identify as:
☐ Male ☐ Female
☐ Transgender Male (Female to Male)
☐ Transgender Female (Male to Female)
☐ Choose Not to Disclose ☐ Other

*Sexual Orientation: (Not required if under the age of 18.)

☐ Straight (Not Lesbian or gay)
☐ Lesbian or Gay ☐ Bisexual
☐ Something Else ☐ Don't Know
☐ Choose Not to Disclose

***Sexual orientation and gender identity can play a significant role in determining health outcomes. Please see the front desk or ask your healthcare team if you have questions about disclosing this information.**

HUNTER HEALTH

Health Record #
(For office use only)

Internet Access: ☐ Yes ☐ No	Where: (Home, Mobile, Etc)	Email Address:
Do we have permission to send generic health information to your email address? ☐ Yes ☐ No		
Preferred Method of Communication: ☐ Email ☐ Letter ☐ Phone ☐ Do Not Notify		

IF PATIENT IS UNDER AGE 18:

Legal Guardian:	Relationship to Patient:

Father's Name:	Father's Employer:	Phone:
Mother's Name:	Mother's Employer:	Phone:

INCOME INFORMATION

Number in Household:_____	Total Household Income: _____ Per Year/ Month/ Bi-Weekly/ Week (Circle One)

INSURANCE INFORMATION

Type of Insurance: ☐ Medicare ☐ Medicaid ☐ Private Insurance ☐ None

Insurance Company:	ID #:

Subscriber Name:	Subscriber Date of Birth:	Sex: ☐ M ☐ F

IN CASE OF EMERGENCY

Emergency Contact Name: Last First Middle

Street Address:			Relationship:	
City	State	Zip Code	Home Phone:	Cell Phone:

Next of Kin

Name: Last First Middle

Street Address:			Relationship:	
City	State	Zip Code	Home Phone:	Cell Phone:

Please bring the following to your appointment:

___Photo ID
___Proof of Income
___Insurance Card (if applicable)
___Tribal Identification/Verification (if applicable)
___Other:_____

HUNTER HEALTH

Health Record #
(For office use only)

Hunter Health

PERMISSION TO DISCLOSE CONFIDENTIAL INFORMATION &Acknowledgement
Of Receipt of Notice of Privacy Practices

I authorize Hunter Health to use and disclose the health and medical information of

_____
(Name) (DOB)

_____ for the following purposes:
(Address) (Phone)

- Treatment- (Performed by a health care provider in this clinic, coordinating or managing care provided to you with third parties, and consultation with and between physicians and other health care providers.)

- Health Care Operations- (Includes the necessary administrative and business functions of your health care provider.)

- Other- **(List family, friends, etc. who you would like to have access to your protected health information):** ☐ **NONE**
  _____
  _____

You may review our **"Notice of Privacy Practices"** for additional information about the uses and disclosers of information described in the CONSENT prior to signing the CONSENT.

By signing below, you verify that you have received a copy of, or been offered, Hunter Health's Notice of Privacy Practices.

You have the right to revoke this CONSENT, in writing at any time. This will not include information we have already used or disclosed in reliance with this CONSENT.

_____ _____
Signature of Patient/ Patient Representative Date

_____
Relationship to Patient

HUNTER HEALTH

Health Record #
(For office use only)

Authorization

Hunter Health is dedicated to providing comprehensive primary care, dental, and behavioral health services. Because wellness involves both the body and mind, our team of providers work together to offer you high quality whole person healthcare. Your providers may involve other healthcare specialists as part of your care team. Members of your health care team will collaborate and share clinical information as needed to ensure enhanced continuity of care.

I understand that if I am 16 years of age or older, I may consent for certain types of health services, including mental health services; if I am 18 years of age or older, I may consent for all other health services; otherwise my parent or legal guardian will need to consent to services. By signing this form, (parent or legal guardian signature, if required) I agree that I have read or had this form read and/or explained to me, that I understand it and that any questions I asked have been answered. I understand that I agree to be truthful in providing information.

Thus, I _____ , hereby ask for , agree, and consent to evaluation and treatment for myself and/or child(ren) as set forth above, including any diagnostic evaluations ,treatment interventions and/or procedures that Hunter Health professional staff decide are necessary or appropriate. If signing as parent or guardian, I hereby represent and warrant that I am legally empowered and entitled to make such decisions.

Assignment of Benefits

I request that payment of authorized benefits be made on my behalf to Hunter Health for any services furnished the patient listed above by Hunter Health physicians and health care providers, and I assign my right to receive these payments to Hunter Health. I authorize Hunter Health to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my Health Insurance Plan will not direct payment to Hunter Health, I agree to forward to Hunter Health all health insurance payments, which I receive for the services rendered by Hunter Health and its health care providers.

Patient Responsibility

I acknowledge that I am responsible for all charges for services provided to the patient listed above which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan. To the extent no coverage exists, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges. I further agree that, if permissible by law, I will reimburse Hunter Health for all costs, expenses and attorney's fees that may be incurred by Hunter Health to collect those charges.

Signature

_____	_____	_____
Signature of Patient/ Patient Representative	Relationship to Patient	Date