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REGISTRATION FORM

(Please Print)

PATIENT INFORMATION					
Last Name:	**First Name:**	**Middle Initial:**	**Birth Date:**	**Sex:** ☐M ☐ F	
Street Address:	**City:**	**State:**	**Zip:**	**County:**	
Mailing Address: ☐Same as above			**Social Security Number:**		
Home Phone Number:	**Cell Phone Number:**		**Work Phone Number:**		
Email Address:	**Marital Status:** ☐Divorced ☐Married ☐Single ☐ Separated ☐Widowed		**Homeless Status:** ☐ Transitional ☐Doubling Up ☐ Homeless Shelter ☐ Other ☐Homeless ☐Seasonal ☐Migrant		
Race: ☐Asian ☐ American Indian/Alaskan Native ☐Black or African American ☐White ☐ Native Hawaiian ☐Pacific Islander ☐Unreported/Refused to Report			**Primary Language:** _____ **Translator Needed:** ☐Yes ☐No		
Ethnicity ***(choose only one):*** ☐Hispanic/Latino ☐Not Hispanic ☐Refused to report			**Veteran Status** (***choose only one):*** ☐Yes ☐No		
Employer Name :	**Employer Status:** ☐Full Time ☐Part Time		**Student:** ☐Yes ☐No		
Primary Care Provider (PCP) Name:					
Does the patient have any problems with: ☐Vision ☐Hearing ☐Reading ☐Speaking **Explain:**					
Parent/Guardian OR Responsible Party Name:	**Address:** ☐Same as above		**Phone Number:**		
Parent/Guardian OR Responsible Party SSN:	**Birth Date:**		**Relationship:**		

MEDICAL INSURANCE INFORMATION				
(Please give your insurance card to the Patient Service Representative)				
Person responsible for bill:	**Birth date:**	**Address (if different):**	**Primary Phone Number:** ( )	
Occupation:	**Employer:**		**Employer Phone Number:**	
Patients relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Step Child ☐Other				
Primary Medical Insurance:	☐Medicare	☐Medicaid	☐Blue Cross Blue Shield	☐Other:
Subscriber's Name:	**Birth Date:**	**Policy #:**	**Group #:**	
Name of Secondary Medical Insurance (if applicable):	**Subscriber's Name:**	**Birth Date:**	**Policy #:** **Group #:**	

IN CASE OF EMERGENCY		
Name of local friend or relative:	**Relationship to patient:**	**Primary Phone Number**

Signature: _____ **Date:** _____

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Sliding Fee Discount Eligibility

It may be necessary to ask some personal questions in order to determine eligibility for a discount on medical, dental or qualified behavioral health services. This information is private and confidential and is kept on file at Swope Health. Income verification is determined once a year and requires proof of income and proof of address documents to be returned to Swope Health Services. (Family size and annual gross household income are used to calculate discount and level of payment.)

List all Household Members that live in the home.

	Name	Date of Birth	Relationship
1			
2			
3			
4			
5			
6			
7			
8			

Do you have any wage income from any of the listed household members:

Household Member Name	Hourly Rate	Hours Worked	Bi-weekly Income	Hours Worked

Do you have income from the any of the following sources and if so, how much per month?

Sources	You	Your Spouse	Your Children	Other Persons	Total Sources
Social Security					
Public Assistance					
Retirement Pension					
Rental Income					
Interest Income					
Child Support-Alimony					
Other (Specify)					

The Sliding Fee, Health Levy, and all other discount programs have been explained to me, and I acknowledge that deliberately providing false or incomplete information in regard to determining the level of sliding fee scale discount can disqualify me or family members from being eligible for this program. I also understand that if I do not provide proof of income and/or proof of address within 30 days, I may be billed at full price for service rendered. Information can be returned in person or to PSRGroupMail@swopehealth.org

Signature_____ **Date**_____

April 2020

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Acceptable Documentation for Sliding Fee Program

If you are not insured, fees for clinic services are based on your income and family size and may be reduced if you live on a limited income, according to state and federal guidelines. To qualify for discounts, you must present the following information, as applicable, when you register:

Proof of Income: (please provide applicable documentation for each household member):

- Current Paycheck Stub including your hourly rate or hours worked, gross pay, and the pay period.
- Letter on Company Letterhead including your hourly rate, gross pay, and the pay period

  *If your employer does not have company letterhead, we will accept a notarized letter.
- W2 Forms (Adjusted Gross Income)
- Current Financial Aid Documents
- Current Unemployment Determination Letter
- Social Security, Pension, Trust, Disability Award Letter , Food Stamp Summary, or Child Support Check
- Bank Statements showing consistent Payroll deposits
- Current Tax Return Information (Adjusted Gross Income)

Proof of Address: (please provide if you live in the city of Kansas City, Missouri)

- Driver's License (address must match current address listed on registration)
- A current piece of mail addressed to you (within 30 days)
- Lease or Mortgage Agreement
- Mail received from the Government (Social Security, pension, trust, SSI Disability Award letter, food stamp budget summary or child support check)
- Current Utility Bill (electric, gas or telephone)
- Current Paycheck Stub with your current mailing address located on the check stub
- Current Bank Statement
- Attestation from a Social Worker (For Homeless Individuals)

Additional Information

- For elderly parents living with adult children or adult grandchildren, include income if adult children or adult grandchildren claim parents as dependents on their tax return. Otherwise, parents should be considered as independent for the purposes of income, without their adult children's income.
- Non-cash items such as food stamps are not included in income.

Please Note: This information must be given to Swope Health within 30 days or you may be billed at full price for services rendered. Information can be returned in person or to PSRGroupMail@swopehealth.org

April 2020

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SELF-DECLARATION OF INCOME

I certify that my current annual household income is $_____ and my family size is _____. I declare that all of my dependents are 18 years old and younger or disabled. I understand that this self-declaration is good for 30 days only. To receive a discount on services for a 12 month period, I will need to provide proof of my income by_____.

❑ I decline to participate in the sliding fee discount program.

_____ _____
Patient/Parent/Legal Guardian Signature Date

FINANCIAL RESPONSIBILITY

I hereby certify that I have not knowingly withheld any information or income or other financial resources. The amounts I have disclosed are true and correct to my knowledge. I understand that hiding information or providing false information may result in prosecution or being removed from Medicaid, Medicare and any other Government funded programs.

I understand the charges I have to pay for are after I received credit for all appropriate discounts and all collections received by Swope Health from health insurance benefits for the above named individuals. I am responsible for the remaining balance.

I agree to pay these charges on the day that the services are provided, within 10 days of receipt of the statement from Swope Health Services or by some other payment arrangement agreed to by the Swope Health Patient Relations Office, telephone **816-599-5700**. I also authorize release of information about any claim to my health insurance carriers, or my state medical assistance agency and/or to the Department of Mental Health.

_____ _____
Patient/Parent/Legal Guardian Signature Date

_____ _____
Witness Date

GENERAL CONSENT FOR DIAGNOSIS AND TREATMENT

I, having registered at Swope Health Services for the purposes of obtaining health services, do hereby, voluntarily consent to diagnostic and treatment services for _____ (Patient Name), as might be provided by or at the direction of a physician, dentist, other health care professional or other qualified member of the staff of the Swope Health Services to me according to his/her judgment. By signing below, I also consent to treatment by students in residency and/or affiliation programs with Swope Health Services.

- I recognize that I have the right to refuse any specific diagnostic or treatment service without jeopardizing my right to receive health services at the Center.
- I recognize that I may be asked to sign a specific consent for surgical and other special procedures including general and/or extensive local anesthesia.
- I am aware that health services are person specific, and I acknowledge that no guarantees have been made to me as to the results of any treatment services,
- I hereby authorize Swope Health Services to retain, preserve and use for scientific or teaching purposes or dispose of at their convenience any specimen or tissue taken from my body during my treatment.

This form has been fully explained to me, and I certify that I understand its contents.

_____ _____
Patient/Parent/Legal Guardian Signature Date

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

I was offered a copy of the Swope Health Notice of Privacy Practices. I have been given the opportunity to read, or have read to me, the Notice of Privacy Practices, which describes how medical information about me may be used and disclosed. I agree with the Notice of Privacy Practices and understand that at any time upon request, I may obtain a copy of it.

_____ _____
Patient/Parent/Legal Guardian Signature Date

RECEIPT OF PATIENT RIGHTS & RESPONSIBILITIES

I was offered a copy of Swope Health "Patient Bill of Rights," also known as Patient Rights and Responsibilities. This document lists my rights as a patient, including the right to access my own information and the right to formulate an advanced directive, among other things. I have been given the opportunity to read it, or have it read to me. I understand what it means, what I might expect from this health care facility and what is expected of me and my family member(s) as registered patients here.

_____ _____
Patient/Parent/Legal Guardian Signature Date

OPTIONAL: PERSONAL REPRESENTATIVE DESIGNATION

A Personal Representative is a person authorized by the patient to obtain information and act on the behalf of another person in making health care related decisions. I understand that completing this form will allow Swope Health to speak to my Personal Representative regarding all health information, including but not limited to illnesses, injuries, test results, medications, and sensitive data that may include:

Alcohol or substance abuse problems	Genetic diseases or tests;
Family Planning information	HIV/AIDS
Sexually Transmitted Diseases	Mental Health and Developmental Disabilities.

I also understand it will give the Personal Representative the ability to do the following on my behalf:

- Make appointments for health care services;
- Have discussions with health care providers about routine tests and treatments; and/or
- Access protected health information.

My authorization is given freely with the understanding that:

- I may refuse to sign this authorization;
- I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing;
- Swope Health Services may not condition my treatment on this; and
- Swope Health Services is not responsible or liable for disclosure of the above information to the extent indicated and authorized herein.

I hereby designate the below person as my Personal Representative:

Name of Personal Representative: _____

Personal Rep Date of Birth: _____ Phone Number: _____

This authorization will expire **(check one)**: ❑Until revoked in writing ❑Date: _____

_____ _____
Patient/Parent/Legal Guardian Signature Date

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COMMUNICATION PREFERENCES

Swope Health is committed to protecting your information. SHS would like to send you information about your healthcare using the methods you prefer.

Please initial next to the forms of communication you authorize Swope Health Services to use to communicate with you.

_____ **Patient Portal**

_____ **Voicemail**

_____ **E-Mail**

_____ **Text Message**

I hereby authorize Swope Health Services to communicate my health information to me using the methods I have consented to above. I understand that the Patient Portal is a secure method of communication, but that communication such as text messaging, email, and voicemail may be considered unsecure and could be seen or heard by others.

_____ _____

Patient/Parent/Legal Guardian Signature Date

HEALTH INFORMATION EXCHANGE

Swope Health participates in three Health Information Exchange networks: Missouri Health Connection ("MHC"), Lewis and Clark Information Exchange ("LACIE"), and Kansas Health Information Network ("KHIN"). These secure networks allow doctors and other caregivers to electronically share a patient's health records with other participating organizations, to improve coordinated care.

I understand a full list of member organizations can be viewed at the MHC, LACIE, and KHIN websites. I also understand only authorized health care organizations and professionals involved in a patient's treatment, care, quality improvement, or payment are allowed access to a patient's records and privacy laws still apply.

❑ I **agree** to participate in the Health Information Exchange and allow other healthcare providers to be able to see my health records from both before and after today's date. I understand this may include illnesses or injuries, test results, medicines I am taking or have taken, and sensitive data including but not limited to: alcohol or substance abuse problems, sexually transmitted diseases, HIV/AIDS, family planning information including abortions, and mental health disabilities.

❑ I **decline** to participate in the Health Information Exchange. I understand other organizations who are trying to help me by providing medical care may not have access to my medical history.

_____ _____

Patient/Parent/Legal Guardian Signature Date