PATIENT REGISTRATION FORM

(Please Print)

PATIENT DEMOGRAPHIC INFORMATION

Patient's Legal Name (First, Middle Initial, Last):	Social Security Number: – –	Birth Date: / /

Preferred First Name:	Maiden Name:	Gender at Birth: ☐ Male ☐ Female

Physical Street Address:	City:	State:	Zip Code:

Mailing Address: ☐ Same as Above	Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Email Address: ☐@gmail.com ☐@hotmail.com ☐@yahoo.com ☐@live.com	Phone Numbers where messages can be left: Primary Phone Number: ( ) ☐ Home ☐ Cell ☐ Other	Secondary Phone Number: ( ) ☐ Home ☐ Cell ☐ Other

Preferred Pharmacy:	Preferred Pharmacy Street & City:

Does the patient have any problems with: ☐ Vision ☐ Hearing ☐ Reading ☐ Speaking Explain for any boxes checked:

PARENT/LEGAL GUARDIAN INFORMATION

Person(s) listed must be both legal parent(s) and/or legal guardian(s).

***Legal documentation is required if person(s) listed are not the custodial parent(s) or if a parent's legal rights have been terminated.**

Parent/Legal Guardian Name:	Phone Number: ( )	Birth Date: / /

Relationship Type: ☐ Mother ☐ Father ☐ Legal Guardian* *Attach legal documentation	Address: ☐ Same as Child

Parent/Legal Guardian Name:	Phone Number: ( )	Birth Date: / /

Relationship Type: ☐ Mother ☐ Father ☐ Legal Guardian* *Attach legal documentation	Address: ☐ Same as Child

PERSON(S) WHO MAY ACCOMPANY MINOR PATIENT (PATIENTS UNDER THE AGE OF 18) AND MAKE MEDICAL/DENTAL/BEHAVIORAL HEALTH TREATMENT DECISIONS

Name:	Phone Number:	Relationship to Patient:
Name:	Phone Number:	Relationship to Patient:

PERSON(S) WHO MAY BE NOTIFIED IN CASES OF EMERGENCY OTHER THAN PARENT/LEGAL GUARDIAN

This does not give the individual(s) listed, authority to accompany minor to appointment or access medical records.

Name:	Phone Number:	Relationship to Patient:
Name:	Phone Number:	Relationship to Patient:

All questions must be answered

Katy Trail Community Health (KTCH) is required to ask the following information from all patients served to help us obtain Federal funding to support our community.

RACE:

Please check all that apply

- ☐ White
- ☐ Black/African American
- ☐ American Indian/Alaskan Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Choose not to disclose

ETHNICITY:

- ☐ Latino/a or Hispanic
- ☐ Not Hispanic, Latino/a or Spanish Origin
- ☐ Another Hispanic Latino/a or Spanish Origin
- ☐ Mexican, Mexican American, Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Choose not to disclose

PRIMARY LANGUAGE:

- ☐ English
- ☐ Spanish
- ☐ Russian
- ☐ Ukrainian
- ☐ Other: _____

GENDER IDENTITY:

- ☐ Male
- ☐ Female
- ☐ Transgender Male (Female-to-Male)
- ☐ Transgender Female (Male-to-Female)
- ☐ Gender Neutral
- ☐ Choose not to disclose

SEX BY ORIENTATION:

- ☐ Straight or heterosexual
- ☐ Lesbian, gay or homosexual
- ☐ Bisexual
- ☐ Something else
- ☐ Don't know
- ☐ Choose not to disclose

HIGHEST LEVEL OF EDUCATION:

- ☐ Not yet in school
- ☐ Pre-School/Kindergarten
- ☐ Grade School
- ☐ Middle School
- ☐ High School (Currently)
- ☐ High School Grad/GED
- ☐ Did Not Complete High School
- ☐ Technical/Trade School
- ☐ Some College
- ☐ College Graduate

HOUSING:

- ☐ Own
- ☐ Rent
- ☐ Public Housing (Income-Based)
- ☐ Homeless

Homeless Status:

- ☐ Doubling Up (staying with others)
- ☐ Street
- ☐ Shelter
- ☐ Transitional Housing

ARE YOU A VETERAN?

- ☐ Yes
- ☐ No

EMPLOYMENT STATUS:

- ☐ Full Time
- ☐ Part Time
- ☐ Seasonal
- ☐ N/A

INCOME STATUS:

Number of Persons in Household: _____

Estimated Annual Household Income:

- ☐ $10,000 or below
- ☐ $10,001 – $20,000
- ☐ $20,001 – $30,000
- ☐ $30,001 – $40,000
- ☐ $40,001 – $50,000
- ☐ $50,001 – $60,000
- ☐ $60,001 – $70,000
- ☐ $70,001 – $80,000
- ☐ $80,001 – $90,000
- ☐ $90,001 – $100,000
- ☐ over $100,000

CONSENTS & AGREEMENTS

Consent to Treat

By signing below, I am giving consent for myself/my ward to receive any treatment as deemed necessary by the attending health care provider. KTCH provides services without regard to race, color, religion, sex (including pregnancy, gender identity, and sexual orientation), national origin, age, disability, genetic information, military service, parental status or number of pregnancies, or marital status. By signing below, I also consent to treatment for myself/my ward by KTCH dental providers and/or students from UMKC school of dentistry and SFCC when or if dental services are provided. When Behavioral Health Services are provided: by signing below, I give consent for myself/my ward to receive treatment from KTCH behavioral health (BH) providers and consent for my ward to be seen without my presence during this appointment if deemed appropriate by BH provider. Additionally, I understand that Title X services are provided solely on a voluntary basis, and acceptance of a family planning service is not a prerequisite to eligibility or receipt of any other service.

Initial: _____

Consent to Obtain External Prescription History:

By signing below, I am giving consent for KTCH to view my external prescription history via its electronic medical record system (eClinicalWorks). This will allow my provider to have information regarding medications I'm taking in order to help minimize adverse drug reactions. By accepting this, I understand that prescription history from multiple unaffiliated medical providers, insurance companies, and pharmacies may be viewed by my provider and authorized staff. I understand that this consent will remain in effect until the day I revoke my consent in writing, and that if I choose to revoke this consent, it will not have an effect on my treatment.

Initial: _____

Consent & Agreement for Patient Portal:

KTCH is committed to protecting its patients' personal health information in compliance with the law. By signing below, I am requesting that KTCH register my email for its patient portal (Healow). By signing below, I am also acknowledging that I have read, fully understand, agree and am aware of the risks and benefits associated with online communication via the patient portal. I agree to adhere to the policies set forth by KTCH as well as any other instructions or guidelines that may be imposed for online communications.

Initial: _____

By signing below, I am acknowledging that I have completed the information in this packet to the best of my knowledge. By signing below and initialing on the above lines, I am acknowledging that I have read and understand the above information.

SIGNATURE: _____ **Date:** _____

Printed Name: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Other: _____

INSURANCE INFORMATION

Please provide a copy of ALL insurance cards

MEDICAL INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE

Insurance Name:
☐ Medicare ☐ Medicaid ☐ BCBS/Anthem ☐ UHC ☐ Tricare ☐ Other Commercial: _____

Member/ Subscriber ID Number:	Group Name:	Group Number:

Subscriber Name: ☐ Patient is Subscriber	Subscriber Phone Number:	Subscriber Birth Date:
	( )	/ /

Subscriber SSN:	Subscriber Address: ☐ Same as patient	Subscriber Relationship to Patient:
		☐ Father ☐ Mother ☐ Spouse ☐ Legal Guardian

SECONDARY MEDICAL INSURANCE (If Applicable)

Insurance Name:
☐ Medicare ☐ Medicaid ☐ BCBS/Anthem ☐ UHC ☐ Tricare ☐ Other Commercial: _____

Member/ Subscriber ID Number:	Group Name:	Group Number:

Subscriber Name: ☐ Patient is Subscriber	Subscriber Phone Number:	Subscriber Birth Date:
	( )	/ /

Subscriber SSN:	Subscriber Address: ☐ Same as patient	Subscriber Relationship to Patient:
		☐ Father ☐ Mother ☐ Spouse ☐ Legal Guardian

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Insurance Name and Claims Address:

Member/ Subscriber ID Number:	Group Name:	Group Number:

Subscriber Name: ☐ Patient is Subscriber	Subscriber Phone Number:	Subscriber Birth Date:
	( )	/ /

Subscriber SSN:	Subscriber Address: ☐ Same as patient	Subscriber Relationship to Patient:
		☐ Father ☐ Mother ☐ Spouse ☐ Legal Guardian

SECONDARY DENTAL INSURANCE (If Applicable)

Insurance Name and Claims Address:

Member/ Subscriber ID Number:	Group Name:	Group Number:

Subscriber Name: ☐ Patient is Subscriber	Subscriber Phone Number:	Subscriber Birth Date:
	( )	/ /

Subscriber SSN:	Subscriber Address: ☐ Same as patient	Subscriber Relationship to Patient:
		☐ Father ☐ Mother ☐ Spouse ☐ Legal Guardian

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose Protected Health Information (PHI).

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your PHI is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your PHI and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- PHI may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Below, please list the individuals you consent for KTCH to share your medical and dental records:

PERSON(S) YOU CONSENT FOR KTCH TO SHARE YOUR MEDICAL AND DENTAL RECORDS.		
Name:	Phone Number:	Relationship to Patient:
Name:	Phone Number:	Relationship to Patient:
Name:	Phone Number:	Relationship to Patient:

SIGNATURE: _____ **Date:** _____

Printed Name: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Other: _____

PATIENT FINANCIAL INFORMATION

IMPORTANT NOTICE TO OUR PATIENTS - PLEASE READ CAREFULLY

- Our Sliding Fee Discount Program is designed to help you pay for medical, dental, and behavioral health services provided by KTCH. If you would like to apply for our sliding fee discount program, please ask the front desk for a sliding fee program application or request an appointment with our Sliding Fee Discount Program Coordinator. You must complete the application and provide proof of income to be certified for the sliding fee discount prior to any appointment that you would like the sliding fee to apply.

- Your child may be eligible for a Medicaid program so please ask for an appointment with one of our Care Coordinators to explore this option.

- Your payment today may be by cash, check, or credit / debit card. Your minimum co-pay is due at the time of check-in, or your appointment will be rescheduled. The only exception will be when your medical/dental condition is considered an emergency which will be determined by our triage nurse/dental coordinator using guidelines established by our Chief Medical /Dental Officer.

- If you participate in a health insurance network, Katy Trail will be happy to file the insurance claim on your behalf. It is your responsibility to pay the balance of any fees for services not covered under your insurance plan upon receipt of the bill or as agreed upon in your payment plan. Should you foresee needing financial assistance to pay this balance; you must complete the sliding fee application and provide proof of income before the time of service to be certified for the slide at that time.

- If you do not participate in a health insurance network & have income over 200% of the poverty level, a deposit of $130 will be required for services you are receiving today. **You will also receive a bill for any fees in excess of your deposit.** Should the fees for medical service be less than your deposit, the difference will be refunded to you. It is your responsibility to pay the balance of any fees for services upon receipt of the bill or as agreed upon in your payment plan.

Initial: _____

Katy Trail firmly believes that a good provider/patient relationship is based upon understanding and good communications. The above information was provided to avoid any misunderstandings. Questions about financial arrangements should be directed to our billing office at 1-877-733-5824 ext. 1156. By signing below as the patient or other patient representative, you acknowledge that you have read this Patient Financial Information sheet and agree to the terms stated.

_____ _____

Signature of Patient or Responsible Party Date

PATIENT RIGHTS

At Katy Trail Community Health, we are committed to providing you with a **Patient Centered Medical Home (PCMH)**. A patient centered medical home is not a place of residence and does not change where you live. Instead, a medical home is where you get healthcare and see your primary care provider (PCP). A PCP can be a doctor, nurse practitioner or a dentist. Your PCP leads a team of individuals within the organization who, as a care team, will take responsibility for the ongoing care of each patient. You and your family are an essential part of the care team. As a patient, you have certain rights. Understanding those rights will help you to get the best possible care. You have the right to:

- Receive compassionate and respectful care regardless of age, sex (including pregnancy, gender identity, and sexual orientation), race, color, national origin, religion, disability, genetic information, military service, marital status, parental status, number of pregnancies, or communicable disease.
- Personal Provider – each patient has an ongoing relationship with a primary care provider (PCP) who will give complete and continuous care.
- Comprehensive Medical Care – the PCMH is responsible for meeting the majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. You have the right to be well informed about your diagnosis, treatment, and chances for recovery in words you can understand. This information should include the specific treatment, medical risks, benefits, and side effects.
- Comprehensive Dental Care - the PCMH is responsible for meeting the majority of each patient's oral health care needs, including prevention and wellness and acute care. You have the right to be well informed about your diagnosis, treatment, and chances for recovery in words you can understand. This information should include the specific treatment, medical risks, benefits, and side effects.
- Provider Directed Medical Practice – the PCP leads a team of individuals within the organization who, as a care team, will take responsibility for the ongoing care of each patient. **Your care team includes your medical PCP, medical assistant, LPN, behavioral health consultant, care coordinator, and a case manager.** The care team will support the patient for self-management of their health and health care goals.
- Provider Directed Dental Practice - the PCP leads a team of individuals within the organization who, as a care team, will take responsibility for the ongoing care of each patient. **Your care team includes your dental PCP, hygienist, dental assistant, expanded functions dental assistant, behavioral health consultant, and care coordinator.** The care team will support the patient for self-management of their oral health and oral health care goals.
- Whole Person Orientation – the PCP is responsible for providing for the entire patient's healthcare needs and takes responsibility for appropriately arranging care with other qualified professionals as needed.
- Behavioral Health Needs – The PCMH employs or contracts for BH Consultants and Psychiatrists. Your PCP may refer you to behavioral health for either chronic disease management or mental health services.
- Care is Coordinated – the PCMH coordinates care across all areas of the health care system, including specialty care, hospitals, home health care, and community services and supports. Such coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital.
- Accessible Services – a PCMH delivers services that are easy to get and with shorter waiting times for urgent needs, better in-person hours, and around-the-clock telephone access to a member of the care team. **The after-hours phone number is 660-851-7765**
- Quality and Safety – PCMH's are dedicated to improving quality of care by using evidence-based medicine and clinical decision-making tools to help providers, patients and families make decisions. Patients will always have the right to refuse recommended treatment to the extent permitted by law, and to be told what will happen to you medically if that is your choice. Express verbally or by letter any complaints or recommendations concerning our services. You may communicate a complaint or grievance in writing at our main site at 821 Westwood, Sedalia, MO 65301, or by calling our main site at 877-733-5824.
- Privacy – You have the right to the privacy and confidentiality of all your records pertaining to your treatment, except as required by law or third-party payment. Your medical and dental record can be read only by individuals directly involved in or supervising your treatment, monitoring the quality of your treatment, or authorized by law or regulation. You have the right to access the information contained in your medical record, within the limits of the law and facility policy. Please refer to the KTCH Notice of Privacy for additional information on your privacy rights.

PATIENT RESPONSIBILITIES

The care you receive is partially dependent upon your acting in a cooperative manner with your health care providers, including communicating openly and honestly, following treatment plans, and respecting the facility standards of conduct. As a patient at Katy Trail Community Health, you are responsible for:

1. Following all facility rules as posted inside and/or outside the clinical facility. Respecting and considering other people, employees, the property of others, and property of Katy Trail Community Health.
2. Advising us of any changes in the following:
   Name, Address, Phone Number(s), Insurance Information, Income, and Family Size
3. Providing accurate and complete information about current symptoms, medical history, hospitalizations, medications, care obtained outside the practice, self-care information, advance directives, and any other matters related to care.
4. Following instructions that you and your care team have agreed upon. Follow through on goals for self-management of your health.
5. Asking questions about your care that you may not understand or have questions about, including risks of procedures, outcomes, and costs of treatment.
6. Knowing what medications or drugs you are taking, why you are taking them, and the proper way to take them according to your PCP's instructions.
7. Calling your pharmacy to request a refill 1 week before you run out of your prescription. If authorized by a KTCH provider, your request will be filled within 72 business hours.
8. Paying bills and fees promptly as defined in the financial policies.
9. Attending to and supervising your children while in the facility.
10. Keeping scheduled appointments, arriving on time for scheduled appointments, and calling at least 4 hours in advance to cancel when you cannot keep a scheduled appointment. KTCH reserves the right to terminate service to patients who do not show for appointments more than three times in a 12-month period.

    MEDICAL: New patients are required to arrive 30 minutes in advance of their appointment. Please notify us at least 4 hours in advance of appointment cancellations. After missing four medical/behavioral health appointments within a calendar year the patient will be required to make all future appointments through the triage nurse. Patients may be removed from the list after writing a letter stating what steps they will take to ensure future appointments are not missed.

    DENTAL: New patients are required to arrive 30 minutes in advance of their appointment. If you are more than **10 minutes late for your dental appointment**, your appointment will be rescheduled. Please notify us at least 24 hours in advance of appointment cancellations. After missing two dental appointments the patient will be required to meet one of the following criteria: wait six (6) months to schedule an appointment, write the provider a letter asking for the privilege to be seen again, or meet with a care coordinator to discuss barriers to care.

I have read and understand the Katy Trail Community Health **Patient Rights and Patient Responsibilities** and have been given an opportunity to obtain a copy for my personal records.

_____ _____

Signature of Patient or Responsible Party Date

Katy Trail Community Health

To provide the highest level of care to you, we ask that you complete the following **AUTHORIZATION TO DISCLOSE and/or OBTAIN PERSONAL HEALTH INFORMATION** and identify all other organizations/providers where you have received care during the past 2 years.

OR

If you would like us to share your records with another organization/provider, please complete the form with their information.

Please ask the front desk for additional forms if needed.

AUTHORIZATION TO DISCLOSE and/or OBTAIN PERSONAL HEALTH INFORMATION

Centralized Medical Records
821 Westwood Drive, Sedalia, Missouri 65301
Phone: 877-733-5824, extension 1171
Fax: 866-208-0157
Email: medrecord@katyhealth.org

Patient's Full Legal Name: _____

Date of Birth: _____ Social Security Number (SSN): _____

Phone Number: _____

I authorize Katy Trail Community Health to (check one):

☐ Release Records **TO** ☐ Obtain Records **FROM** *(Please send records in electronic format via email, fax or CD/Flash Drive)*

Name/Facility: _____

Address: _____

Phone Number: _____ Fax Number: _____

The following information is for treatment received from: Begin Date: _____ **to** End Date: _____

This authorization applies to the below services (Check all that apply):

☐ Medical ☐ Dental ☐ Mental Health (includes Psychiatry and Behavioral Health)

Information to be released - specific to treatment dates & service checked above (Check all that apply):

☐ Visit Notes (last two years)
☐ Laboratory/Diagnostic Test results (last two years)
☐ Immunization (shot) records
☐ Billing Records
☐ Face Sheet - Summary with yours diagnoses, medications & contact information
☐ Specific records pertaining to: _____

Purpose/Reason for disclosure (Check all that apply):

☐ Continuation of Care ☐ Personal Records ☐ Insurance Reasons ☐ Legal Reasons

I understand that my medical, dental, mental health and billing information may include information in reference to drug and/or alcohol abuse, CFR 42 Part 2, psychiatric treatment, sexually transmitted disease, Hepatitis C or Hepatitis B testing or treatment and/or HIV/AIDS (Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information. By signing below, I agree to its release, otherwise by initialing and qualifying this clause here I reject the release of these specially protected records: _____

Revocation Process: I understand that I may, by placing my request in writing to Katy Trail Community Health, revoke this authorization at any time, except to the extent that action has already been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.
If I fail to specify an expiration date, event, or condition, this authorization will expire one year from the date of signature.

Redisclosure: I understand that authorizing the disclosure of this protected health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure, and information may not be protected by federal privacy standards. If I have questions about disclosure of my protected health information, I can contact the Privacy Officer for Katy Trail Community Health.

Prohibition of Redisclosure: Except as provided under Federal Law 45 CFR 164.524, this information has been disclosed from records whose confidentiality is protected by Federal Law 42 CFR Part 2. The recipient of this information is prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

Copy of Release: If you would like a copy of this release, initial here: _____

Patient's Signature: _____ Date: _____

Parent or Legal Guardian/
Representative Signature: _____ Date: _____

Parent or Legal Guardian/Representative Printed Name: _____

Relationship to Patient: _____ ☐ Parent ☐ Legal Guardian ☐ Legal Representative

Office Use Only: Records released by: _____ Date Completed: _____