apicha
community health center

REGISTRATION FORM

REVISED 9/4/14

Legal Last Name	Legal First Name	Preferred First Name	Preferred Pronoun

Address	Apt. #	City	State	Zip Code

Cell Phone Number	Home Phone Number	Primary Contact	☐ Cell ☐ Home	Email Address

Date of Birth	Social Security Number
/ /	- -

Sex assigned at birth
☐ Male ☐ Female

How did you hear about us?
☐ Friend ☐ Brochure ☐ Internet
☐ Patient ☐ Case worker ☐ APICHA website
☐ Doctor ☐ Social media ☐ Outreach

We recognize that the information collected on this form may not reflect all of our community. We are required to collect information for billing and reporting to funders. We recognize and respect your preferred pronoun.

Gender Identity
☐ Male
☐ Female
☐ Trans*Male
☐ Trans*Female
☐ GQ/GNC

Sexual Orientation
☐ Gay
☐ Lesbian
☐ Bisexual
☐ Queer / Something else
☐ Straight
☐ Don't know
☐ Declined to answer

Household Size

Annual Household income

Emergency Contact Information

Name	
Relationship	
Phone number	

Race (Check all that apply)
☐ American Indian / Alaska Native ☐ Black/African American ☐ Native Hawaiian
☐ Asian ☐ White/Caucasian

Hispanic?
☐ Yes
☐ No

Asian Detail
☐ Bangladeshi ☐ Indian ☐ Malaysian
☐ Chinese ☐ Indonesian ☐ Pakistani
☐ Cambodian ☐ Japanese ☐ Thai
☐ Filipino ☐ Korean
☐ Other____________________________

Native Hawaiian/Pacific Islander Detail
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander

Hispanic Detail
☐ Puerto Rican ☐ Central American
☐ Dominican ☐ South American
☐ Cuban
☐ Mexican / Mexican-American / Chicano(a)

Country of birth	Year when you came to US?

Preferred Language	Interpreter needed?
	☐ Yes ☐ No

Registered to vote?
☐ Yes
☐ No

Need help to register?
☐ Yes
☐ No

US Military Veteran?
☐ Yes
☐ No

Migrant Worker?
☐ Yes
☐ No

Employer Information

Name	
Address	
Phone	

Housing Information
☐ Street
☐ Homeless shelter
☐ Transitional housing
☐ Doubling up
☐ SRO / motel
☐ Rent - Public housing (HASA, Section 8, NYCHA)
☐ Rent - Private
☐ Own

Education Achieved
☐ No schooling
☐ 8th grade or less
☐ Some high school
☐ High school (GED)
☐ Some college
☐ Bachelor/technical degree
☐ Post graduate

Insurance Information
☐ Medicaid ☐ Private
☐ Medicaid HMO ☐ ADAP
☐ Medicare ☐ No insurance

If you do not have health insurance we will determine your sliding scale discount based on your income.

Insurance information

Plan Name	
Policy #	
Group #	

Sex listed in health insurance
☐ Male ☐ Female

Policy Holder Information

Name	
Date of Birth	
SSN	

By signing this form I attest that all statements I have made, including my answers to all questions are true and correct to the best of my knowledge.

X	
Signature	Date

For Internal Use Only

Staff Name	

CONSENT AND ACKNOWLEDGEMENT FOR SERVICES

Name:____

Completion of this consent is necessary to offer services to a patient. We need this form completed in its entirety in order for us to provide you with comprehensive care.

Consent for testing and treatment

I hereby authorize APICHA Community Health Center to perform such tests, treatments and procedures as ordered by medical staff for diagnostic and/or therapeutic purposes.

___________ (**Initials**)

Acknowledgment of receipt

I acknowledge that I have been given the following notices: Notice of Privacy Practices, Patient's Rights and Responsibilities, which I agree to abide by, and Grievance Policy for filing complaints.

___________ (**Initials**)

Medicaid / Medicare / Third Party Insurance

I request that payment of authorized benefits be made to APICHA Community Health Center on my behalf, for any services provided to me. I understand that I am responsible for the cost of services delivered that are not covered by my insurance. I also understand that I am responsible for my co-pay, deductible and co-insurance.

___________ (**Initials**)

Financial Responsibility

We realize that the issue of insurance coverage and financial responsibility can be difficult to understand and confusing. Below we created a table to explain most common situations.

___________ (**Initials**)

You have …	**You are responsible for …**	**APICHA will …**
No insurance	➢ Payment for services at the time of visit ➢ Payment of external labs tests, xrays and medications ➢ Work with APICHA staff who will do financial screening ➢ Provide APICHA staff with required financial documents	➢ Conduct financial screening ➢ Determine if you qualify for sliding scale (discount)
Medicaid Managed Care Plan	➢ Select an APICHA PCP ➢ Pay your co-pay, if applicable	➢ Assist you in selecting a PCP ➢ File an insurance claim
Medicaid	➢ Select a Medicaid Managed Care Plan we participate with ➢ Select a PCP	➢ Give you the names of Medicaid Managed Care Plans we participate with ➢ Assist you in selecting a PCP ➢ File an insurance claim
Medicare	➢ Payment of your deductible ➢ Payment of any services not covered by Medicare ➢ Payment of your 20% coinsurance if you do not have secondary coverage	➢ Provide you with receipt for payment ➢ File an insurance claim ➢ Inform you of services that are not covered
Commercial Insurance	➢ Payment of co-pay, deductible, co-insurance ➢ Payment of services not covered	➢ Provide you with receipt for payment ➢ Inform you of services that are not covered