COMMUNITY HEALTH

MEDICAL • DENTAL • BEHAVIORAL HEALTH

## FINANCIAL SERVICES

71 Allen St., Suite 402, Rutland, VT 05701
Phone 802-671-5800 Fax 802-772-7973

# REGISTRATION FORM

| | | | |
|---|---|---|---|
| Patient's first name: | Last: | Middle Initial: | Marital Status: |
| Preferred Name: | Former Name: | Birth date: | Sex: □ Male □ Female |
| Mailing Address: | City: | State: | Zip: |
| Social Security No.: | Home Phone No.: | Cell Phone No.: | |
| Email: | | Work Phone No.: | |
| Pharmacy: | Pharmacy Location: | | |

## INSURANCE INFORMATION

| | | | |
|---|---|---|---|
| Person responsible for bill: | Birth date: | Home Phone No.: | |
| Address (if different): | | | |
| Name of primary insurance: | Subscriber's Name: | | |
| Subscriber's S.S. No.: | Subscriber's Birth date: | Patient's Relationship to Subscriber: | |
| Policy No.: | Group No.: | Effective Date: | Co-payment: |
| Name of secondary insurance (if applicable): | Subscriber's Name: | | |
| Subscriber's S.S. No.: | Subscriber's Birth date: | Patient's Relationship to Subscriber: | |
| Policy No.: | Group No.: | Effective Date: | Co-payment: |

## IN CASE OF EMERGENCY

| | | |
|---|---|---|
| Name of local friend or relative: | Relationship to Patient: | Phone No.: |

**I give my permission for my Health Care Provider at Community Health to discuss my medical condition and/or test results with:**

| | | | |
|---|---|---|---|
| Name: | Relationship: | | |
| Street Address: | City: | State: | Zip: |
| Phone No.: | | | |

***Please provide us with your insurance cards so that we may make a copy for our records.**

I authorize the release of information, including the diagnosis and copies of records of any treatment or examination rendered to me or my dependent during the period of such care, to third party payers and/or other health practitioners. I agree that this consent constitutes any permission that Community Health and medical staff would otherwise be required to obtain under Vermont laws before so using or disclosing my protected health information. I am aware that Community Health privacy practices are further described in the Community Health Notice of Privacy Practices. I give my consent for examination, diagnostic procedures, medical treatments and surgical procedures including local anesthesia, as prescribed by my physician. I acknowledge that no guarantees have been made to me regarding the results of the examination and/or treatment. I authorize and request my insurance company to pay directly to Community Health, benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf, or my dependents in accordance with my health care plan.

I understand that this form gives permission for treatment in accordance with the physician's orders. For the purpose of advancing medical education, I authorize the attendance of healthcare students participating in Community Health programs. I authorize Community Health to examine, retain, and preserve or dispose of any tissues or specimens removed from my body. I authorize my insurance company or employer to discuss matters related to the payment of claims with Community Health.

Signature of Patient/Parent/Guardian _____ Date _____

**Patient name:** _____ **Patient date of birth:** _____ **Account#:** _____

**<u>Please answer all questions on this page.</u> As a Health Center that receives federal funding, we are required to collect this information. Our funding makes sure we can serve anyone who needs our care. All answers are confidential. We appreciate your help!**

**Race:** □ African-American □ Asian-American □ Caucasian/White □ Native American □ Pacific Islander □ Multi-Racial □ Other _____

**Are you a Veteran?** □ Yes □ No **Ethnicity:** □ Hispanic □ Non-Hispanic

**Primary Language:** □ English □ Spanish □ American Sign Other _____

**Do you need an Interpreter?** □ Yes □ No Language: _____

**Are you homeless?** □ Yes □ No If homeless are you: □ Living with others □ Shelter □ Street □ Transitional

**Answer the following 2 questions if you are over 18:**
**Patients Sexual Orientation:** □ Lesbian or gay □ Straight or Heterosexual □ Bisexual □ Something else □ Don't know □ Chose not to disclose

**Patients Gender Identity:** □ Male □ Female □ Transgender Male/Female-to-male □ Transgender Female/Male-to-female □ Other □ Chose not to disclose

**Family Financial Information** Please ***<u>circle</u>*** your family size and household income range below:
□ Chose not to disclose

## *Self-Pay Sliding Fee Schedule*
## *2022 Poverty Level Guidelines*
## *ANNUAL INCOME*

| ***Household Size*** | **100% Discount** $10 Medical Fee Full Subsidy | **90% Discount** $20 Medical Fee plus 10% balance billed 101-135% | **80% Discount** $20 Medical Fee plus 20% balance billed 136-170% | **70% Discount** $20 Medical Fee plus 30% balance billed 171-200% |
|---|---|---|---|---|
| *1* | $0- $13,590 | $13,591- $18,347 | $18,348- $23,104 | $23,105- $27,180 |
| *2* | $0- $18,310 | $18,311- $24,719 | $24,720- $30,588 | $30,589- $36,620 |
| *3* | $0- $23,030 | $23,031- $31.091 | $31,092- $39,152 | $39,153- $46,060 |
| *4* | $0- $27,750 | $27,751- $37,463 | $37,464- $47,176 | $47,177- $55,500 |
| *5* | $0- $32,470 | $32,471- $43,835 | $43,836- $55,200 | $55,201- $64,940 |
| *6* | $0- $37,190 | $37,191- $50,207 | $50,208- $63,224 | $63,225- $74,380 |
| *7* | $0- $41,910 | $41,911- $56,579 | $56,580- $71,248 | $71,249- $83,820 |
| *8* | $0- $46,630 | $46,631- $62,951 | $62,952- $79,272 | $79,273- $93,260 |
| *For each additional person, add* | $4,720 | $4,720 | $4,720 | $4,720 |

*You may qualify for discounted medical care based on your answers above. Please ask the office staff for more information.