

# Patient Registration



PATIENT INFORMATION									
Last Name (Legal)			First Name (Legal)			Middle Initial		Preferred Name (Optional)	
Date of Birth		Social Security #			Marital Status (Legal) Single      Married      Widowed Partner      Divorced/Separated			Gender at Birth Male      Female	
Street Address (with Apt. # if applicable)			PO Box		City		State	Zip Code	
Home Phone #		Cell Phone #		Employment Status Full Time      Part Time Disabled      Retired Unemployed      Student Military - Active Duty			Employer Name		
Contact Preference Phone Call → Home      Cell Text Message      None		Best Time to Contact Morning      Evening Afternoon					Employer Phone #		
Email Address (required for patient portal access and message reminders)					Preferred Pharmacy				
Race White American Indian/Alaska Native Asian Black/African American Native Hawaiian Other/Pacific Islander		Gender Identity Male Female Transgender Male (F to M) Transgender Female (M to F) Other Choose not to disclose		Sexual Orientation Straight or Heterosexual Lesbian, Gay or Homosexual Bisexual Something else Don't know Choose not to disclose		Are you a migrant or seasonal agricultural worker? Yes      No		Ethnicity Hispanic/Latino Not Hispanic/Latino	
						Are you a US Veteran? Yes      No		Primary Language Spoken English Spanish Other _____	
						Are you homeless? Yes      No		Interpreter Needed	
INSURANCE INFORMATION (We will need a copy of your insurance card(s))									
Primary Health Insurance					Secondary Health Insurance				
Health Insurance Company					Health Insurance Company				
Name of Policy Holder (if different from above)					Name of Policy Holder (if different from above)				
Policy Holder's date of birth (if different from above)					Policy Holder's date of birth (if different from above)				
Policy Holder's relationship to Patient (if different from Self) Spouse      Parent      Other _____					Policy Holder's relationship to Patient (if different from Self) Spouse      Parent      Other _____				
Primary Dental Insurance					Secondary Dental Insurance				
Dental Insurance Company					Dental Insurance Company				
Name of Policy Holder (if different from above)					Name of Policy Holder (if different from above)				
Policy Holder's date of birth (if different from above)					Policy Holder's date of birth (if different from above)				
Policy Holder's relationship to Patient (if different from Self) Spouse      Parent      Other _____					Policy Holder's relationship to Patient (if different from Self) Spouse      Parent      Other _____				
Primary Vision Insurance					Secondary Vision Insurance				
Vision Insurance Company					Vision Insurance Company				
Name of Policy Holder (if different from above)					Name of Policy Holder (if different from above)				
Policy Holder's date of birth (if different from above)					Policy Holder's date of birth (if different from above)				
Policy Holder's relationship to Patient (if different from Self) Spouse      Parent      Other _____					Policy Holder's relationship to Patient (if different from Self) Spouse      Parent      Other _____				
EMERGENCY CONTACT (Must be someone other than yourself)									
Emergency Contact Name							Phone #		
Legal Relationship to Patient?      Spouse      Parent      Child      Other _____									

**GUARANTOR INFORMATION (Financially Responsible Individual)**

Guarantor is: Patient is Guarantor (*No need to complete the rest of this section*)  
 Person \_\_\_\_\_ Company \_\_\_\_\_

Patient's relationship to Guarantor  
 Child \_\_\_\_\_ Parent \_\_\_\_\_ Spouse \_\_\_\_\_ Employer \_\_\_\_\_ Other \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender Male \_\_\_\_\_ Female \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Email Address \_\_\_\_\_ Employer Name \_\_\_\_\_

**HOUSEHOLD INCOME GUIDELINES**

PrairieStar Health Center (PrairieStar) is a Federally Qualified Health Center (FQHC). We receive federal funding and grants. As part of this funding, we are required to collect income data on all patients at least once a year. This data is used to set up programs to meet our patient's needs. Patients must be re-certified on or before their sliding fee anniversary date to receive a discount for services.

**PLEASE SELECT THE INCOME THAT BEST DESCRIBES YOUR SITUATION**

Number in Household	1	2	3	4	5	6	7	8
Annual Income Under	\$12,760	\$17,240	\$21,720	\$26,200	\$30,680	\$35,160	\$39,640	\$44,120
Annual Income Between	\$12,761 - \$19,140	\$17,241 - \$25,860	\$21,721 - \$32,580	\$26,201 - \$39,300	\$30,681 - \$46,020	\$35,161 - \$52,740	\$39,641 - \$59,460	\$44,121 - \$66,180
Annual Income Between	\$19,141 - \$22,330	\$25,861 - \$30,170	\$32,581 - \$38,010	\$39,301 - \$45,850	\$46,021 - \$53,690	\$52,741 - \$61,530	\$59,461 - \$69,370	\$66,181 - \$77,210
Annual Income Between	\$22,331 - \$25,520	\$30,171 - \$34,480	\$38,011 - \$43,440	\$45,851 - \$52,400	\$53,691 - \$61,360	\$61,531 - \$70,320	\$69,371 - \$79,280	\$77,211 - \$88,240
Annual Income Over	\$25,521	\$34,481	\$43,441	\$52,401	\$61,361	\$70,321	\$79,281	\$88,241

**PATIENT CONSENT TO SHARE PERSONAL HEALTH INFORMATION (Optional)**

I authorize PrairieStar to share my personal health information with the person(s) below. I understand this authorization is **VOLUNTARY**. I understand that once my information is disclosed, it may be redisclosed by the recipient, and the information may not be protected by Federal privacy laws or regulations. I understand that this consent will remain in effect until I cancel it in writing.

Name	Relationship to Patient	Health Info	Billing	Scheduling	All

**PAY AGREEMENT**

I agree to promptly and fully pay any charges for services I receive at PrairieStar. I understand I will be responsible for any charges not paid by my insurance. I understand I am responsible to check with my insurance provider to see which services are covered. I understand that delinquent accounts are subject to collection activity, including referral to a collection agency.

**EXTERNAL PRESCRIPTION HISTORY**

PrairieStar uses an electronic health record system that allows electronic prescribing of medications. Medications are sent to the pharmacy through a secure electronic prescription connection which improves the timely and accurate transmission of medication information. I agree that PrairieStar may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes. **By initialing the box, I DO NOT authorize PrairieStar to request prescription medication history.**

**ASSIGNMENT OF BENEFITS**

I hereby assign and authorize direct payment to PrairieStar of all insurance payments or other third party payers.

**CONSENT FOR TREATMENT**

I hereby request and give consent for the healthcare professional at PrairieStar to provide medical, dental, vision and behavioral health treatment to me and/or my family.

**AUTHORIZATIONS TO RELEASE INFORMATION**

I authorize PrairieStar to release any health information that may be necessary for either medical care or for processing of insurance benefits.

I request payment of authorized Medicare/Medigap/Medicaid benefits to PrairieStar and authorize release of health information necessary for processing insurance benefits to Centers of Medicare and Medicaid and other insurance agents.

**I hereby certify that the above information is true, and that I have read, fully understand, and accept all terms of the foregoing guidelines.**

SIGNATURE OF PATIENT AND/OR GUARANTOR	DATE
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**NON-COVERED SERVICES & CO-PAY**

As your medical provider, our relationship is with you and not your insurance carrier. PrairieStar will file your claims to your insurance; however, **you are the sole responsible party for all charges that remain after insurance payments.** Failure to provide PrairieStar with current, accurate insurance information will result in all charges becoming the responsibility of the patient/responsible party. **All co-pays, co-insurance, and sliding scale nominal fees are due prior to services being rendered.** These payments do not guarantee payment in full. Statements will be mailed for charges exceeding the initial payment made. For patients with Medicare or Medicaid, please be advised there may be an applicable co-pay for services rendered. If we are not contracted with your insurance company, you will be 100% responsible for the payment at the time of service.

**PAYMENT ARRANGEMENTS**

PrairieStar wants to work with you to meet your healthcare needs at affordable costs. Please contact the patient account representatives at (620) 663-8484 if you need to set up payment arrangements for your account balance. PrairieStar accepts payments in the office, over the phone, on the Patient Portal, or online at <https://www.prairiestarhealth.org>. For your convenience, you can also set up an automatic/recurring ACH agreement.

**NON-PAYMENT FOR SERVICES**

If no payment or payment arrangement has been made with PrairieStar after 90 days from the first statement date, your account will be turned over to an outside collection agency. All patients turned to an outside collection agency are required to make either a \$75 payment (**this is in addition to any co-pays, co-insurance, and sliding scale nominal fees**) at the time of service for all future appointments until the collection balance has been paid in full or set up an automatic/recurring payment agreement with the Business Office via checking, savings, or debit/credit card.

**RETURNED CHECKS/ACH**

PrairieStar charges a **\$30 fee for all checks and \$15 fee for all ACH transactions returned** as non-sufficient funds. The original payment amount, as well as the returned check/ACH fee, will be added to your next statement balance. Checks/ACH's will no longer be accepted on your account and all future payments must be made by cash, debit/credit card, or money order.

**SLIDING FEE SCALE**

PrairieStar offers a sliding fee scale to all income eligible uninsured or under-insured patients and I acknowledge that I was offered the opportunity to apply. This program allows qualifying patients to receive medical, dental, and vision care at a lower cost. Eligibility for the sliding fee scale will be established by determining the household size and the annual combined household income. Valid proof of income includes: two (2) most recent paystubs, most recent annual federal income tax return, documentation of government assistance, disability determination with benefit amount, documentation of child support/alimony, letter from employer on employer letterhead signed and dated by a supervisor, or financial award letter showing grants, scholarships, or fellowships. If the patient declares no income, then the patient can apply for a 90-day, no verifiable income slide. If a patient chooses not to provide the required information, then he/she will not receive discounted rates offered through the sliding fee scale.

Sliding fee scale eligibility is for the duration of one (1) year. Patients are required to re-certify on or before the sliding fee anniversary date and are responsible for providing current proof of income in order to receive a discount. If you are unable to provide proof of income at the time of application, you will have **14 days from the appointment date**, to submit any proof of income in order to backdate any charges.

**APPOINTMENT POLICY**

If you are **5 minutes late** for an appointment, you may have to be rescheduled. Your provider will attempt to work you back into the schedule, but this may be after your scheduled appointment time. If we are unable to work you in, you will have to be rescheduled, and this will count as a *missed appointment without notice*. If you miss **two (2)** scheduled **dental** appointments within a **12 month period of time** without notifying PrairieStar prior to the previous business day, you will be notified via letter that you have been placed on **same-day scheduling**.

**YOUR RIGHTS REGARDING ELECTRONIC HEALTH INFORMATION TECHNOLOGY**

PrairieStar participates in electronic Health Information Technology (HIT). This technology allows a provider or a health plan to make a single request through a Health Information Organization (HIO), to obtain electronic records for a specific patient from other HIT participants for purposes of treatment, payment, or healthcare operations. HIOs are required to use appropriate safeguards to prevent unauthorized uses and disclosures.

You have two options with respect to HIT. First, you may permit authorized individuals to access your electronic health information through an HIO. If you choose this option, you do not have to do anything.

Second, you may restrict access to all of your information through an HIO (except as required by law). If you wish to restrict access, you must submit the required information either online at <http://www.KanHIT.org> or by completing and mailing a form. This form is available at <http://www.KanHIT.org>. You cannot restrict access to certain information only; your choice is to permit or restrict access to all of your information. If you have questions regarding HIT or HIOs, please visit <http://www.KanHIT.org> for additional information.

If you receive healthcare services in a state other than Kansas, different rules may apply regarding restrictions on access to your electronic health information. Please communicate directly with your out-of-state healthcare provider regarding those rules.

**PATIENT ACKNOWLEDGEMENT AND NOTICE OF PRIVACY PRACTICES**

I acknowledge that PrairieStar has provided me with a copy of its Notice of Privacy Practices, which describes how health information about me may be used and disclosed, and how I can access this information. I have been given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that PrairieStar reserves the right to change the terms of this notice periodically, and that I may contact PrairieStar at any time to obtain the most current copy of this notice.

I hereby acknowledge that I have read, fully understand and accept all terms of the financial guidelines and policies stated above.

**SIGNATURE OF PATIENT AND/OR GUARANTOR**

**DATE**