

# PATIENT REGISTRATION

(Please complete both sides in blue or black pen.)

**Guardians: Fill this out as if you are answering as the patient.**

|                       |   |                |       |                              |            |        |  |
|-----------------------|---|----------------|-------|------------------------------|------------|--------|--|
| Today's Date          |   | Date of Birth  |       | Social Security # (required) |            |        |  |
|                       |   |                |       | - -                          |            |        |  |
| Prefix                |   | Last Name      |       | First Name                   |            | Suffix |  |
| Sex Assigned at Birth | <input type="checkbox"/> Male<br><input type="checkbox"/> Female  | Preferred Name |       |                              |            |        |  |
| Pronouns              | <input type="checkbox"/> She/her <input type="checkbox"/> He/him <input type="checkbox"/> They/them<br><input type="checkbox"/> Ze, zie (pronounced "zee")<br><input type="checkbox"/> Hir, hirs (pronounced "here")<br><input type="checkbox"/> Prefer using my name only <input type="checkbox"/> Neo<br><input type="checkbox"/> Other |                |       |                              |            |        |  |
| Gender Identity       | <input type="checkbox"/> Male <input type="checkbox"/> Unknown<br><input type="checkbox"/> Female <input type="checkbox"/> Neither/Non-Binary<br><input type="checkbox"/> Transgender Male <input type="checkbox"/> Choose not to say<br><input type="checkbox"/> Transgender Female<br><input type="checkbox"/> Other                    |                |       |                              |            |        |  |
| Sexual Orientation    | <input type="checkbox"/> Heterosexual <input type="checkbox"/> Lesbian or Gay<br><input type="checkbox"/> Bisexual <input type="checkbox"/> Pansexual <input type="checkbox"/> Asexual<br><input type="checkbox"/> Other <input type="checkbox"/> Unknown<br><input type="checkbox"/> Choose not to disclose                              |                |       |                              |            |        |  |
| Street Address        |   |                |       |                              |            |        |  |
| Mailing Address       |   |                |       |                              |            |        |  |
| City                  |   |                | State |                              | ZIP Code   |        |  |
| Home Phone            |   | Work Phone     |       |                              | Cell Phone |        |  |

Communication may include appointment reminders, notices, feedback and health information.

Please indicate your communication preferences below.

|  |                                |
|--|--------------------------------|
| May we leave phone messages?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Phone number to leave message: |
|--|--------------------------------|

|  |   |
|--|---|
| May we mail the address above?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Do you live in the City Limits?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|---|

|  |                       |
|--|-----------------------|
| May we text you?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Phone number to text: |
|--|-----------------------|

|  |        |
|--|--------|
| May we e-mail you?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Email: |
|--|--------|

|                         |  |               |
|-------------------------|--|---------------|
| Parent or Guardian Name |  | Relationship? |
|-------------------------|--|---------------|

|                         |  |               |
|-------------------------|--|---------------|
| Parent or Guardian Name |  | Relationship? |
|-------------------------|--|---------------|

|                          |  |
|--------------------------|--|
| Custodial Responsibility | <input type="checkbox"/> Joint <input type="checkbox"/> Sole<br><input type="checkbox"/> Other ( <i>please explain</i> ) _____ |
|--------------------------|--|

If patient is 18 years of age or younger, please provide mother's maiden name: \_\_\_\_\_

|  |  |  |
|--|--|--|
| Race<br>( <i>Please check all that apply</i> ) | <input type="checkbox"/> African American/Black                    | <input type="checkbox"/> Caucasian/White |
|  | <input type="checkbox"/> Alaskan Native                            | <input type="checkbox"/> Native Hawaiian |
|  | <input type="checkbox"/> Native American: Tribal Affiliation _____ |  |
|  | <input type="checkbox"/> Asian                                     |  |
|  | <input type="checkbox"/> Pacific Islander                          |  |
|  | <input type="checkbox"/> <i>Refuse to provide</i>                  |  |

|                                  |   |                       |  |
|----------------------------------|---|-----------------------|--|
| Ethnicity                        | <input type="checkbox"/> Latino <input type="checkbox"/> Latina <input type="checkbox"/> Latinx<br><input type="checkbox"/> Hispanic <input type="checkbox"/> Not Latino/Hispanic<br><input type="checkbox"/> <i>Refuse to provide</i>  |                       |  |
| Marital Status                   | <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partner <input type="checkbox"/> Separated<br><input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other   |                       |  |
| Housing Status                   | <input type="checkbox"/> Not Homeless<br><input type="checkbox"/> Homeless Shelter<br><input type="checkbox"/> Doubling up<br><input type="checkbox"/> Street<br><input type="checkbox"/> Transitional Housing  | Who do you live with? |  |
| Military Status                  | Are you active duty? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No  |                       |  |
| Employment Status                | <input type="checkbox"/> Full Time<br><input type="checkbox"/> Part Time<br><input type="checkbox"/> Unemployed<br><input type="checkbox"/> Disabled<br><input type="checkbox"/> Retired<br><input type="checkbox"/> Migrant/Seasonal<br><input type="checkbox"/> Student, what school do you attend? |                       |  |
| Employer                         |   | Occupation            |  |
| Do you have Advanced Directives? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown<br><input type="checkbox"/> Need More information on Advanced Directives  |                       |  |

It is important that we receive a copy of both the front and back of your insurance card(s) to ensure correct billing.

Please provide your cards to the front desk staff or copies can be emailed to [billing@axishealthsystem.org](mailto:billing@axishealthsystem.org).

## EMERGENCY CONTACT

|                |  |              |  |
|----------------|--|--------------|--|
| Name           |  | Relationship |  |
| Contact Number |  | City/State   |  |

## GUARANTOR

|  |  |
|--|--|
| Who is financially responsible for this patient? |  |
| What is their address?                           |  |

## INSURANCE COVERAGE

| Primary Insurance        |  | Secondary Insurance      |  |
|--------------------------|--|--------------------------|--|
| Insurance Name:          |  | Insurance Name:          |  |
| Subscriber Name:         |  | Subscriber Name:         |  |
| Relationship to Patient: |  | Relationship to Patient: |  |
| Member ID #:             |  | Member ID #:             |  |
| Group Number:            |  | Group Number:            |  |
| Effective Date:          |  | Effective Date:          |  |
| Claims Address:          |  | Claims Address:          |  |

☐ Uninsured/Self-Pay

Axis Health System (AHS) is dedicated to ensuring you have access to our services. As a non-profit organization, we receive funding from local, state, federal, and grant funding sources, and we are required to collect financial information from our patients to continue to receive this funding.

By providing your household income below, we may also be able to assist you in determining if you are eligible for a variety of additional health benefit options. In many cases, our staff can assist qualifying patients with the enrollment or assessment process. Some of these include:

- Discounted fees are available for qualified patients who may be unable to pay the full fee for services. AHS offers a sliding scale discount based on income and household size.
- Special grant-funded services
- Public funded health care coverage such as Medicaid or CHP+.

By declining to provide this financial information, you may be ineligible for financial assistance for your care.

All information provided will remain confidential.

|                              |  |                                    |  |                                |  |
|------------------------------|--|------------------------------------|--|--------------------------------|--|
| Total<br>Annual<br>Household |  | # of<br>Individuals<br>In the home |  | # of<br>individual<br>Under 18 |  |
|------------------------------|--|------------------------------------|--|--------------------------------|--|

By signing below, I attest that the above registration information is true and accurate.

Patient or Legal Guardian Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

## **Acknowledgement of Information Received and Consent for Integrated Evaluation and Treatment**

Axis Health System adheres to all state and federal regulations as they apply to the access, protection, disclosure and use of your healthcare information contained in our records. This information is also available to you in a Patient Handbook. I have read the following notices related to the use, disclosure, access and protections associated with my healthcare record. I understand that this practice participates in electronic Health Information Exchange (HIE) and I hereby authorize the release of medical records to the HIE in support of my care and as necessary to process claims related to my care. Currently my lab results are routinely exchanged in the HIE. I also understand that details regarding the privacy protections for my record are contained in Axis's Notice of Privacy Practice. This and the following information is available to me both electronically via email request, at Axis website [www.axishealthsystem.org](http://www.axishealthsystem.org) or by asking for a printed copy at any of our clinic locations:

**Appointment Policy**

**Medical Grievance Policy Behavioral Health Grievance Policy**

**Patient Rights & Responsibilities**

**Notice of Privacy Practices**

**Advance Directives**

**How to Choose a Medical Healthcare**

**Provider**

**Patient Handbook**

I hereby consent to treatment, including tests, procedures and medications, as directed by Axis staff. I understand my treatment will have a greater chance of success when I participate in its design and cooperate with any professional recommendations that are provided to

me. I understand that I may refuse any services and/or treatment and this will not jeopardize my status as a patient of Axis if I have a valid consent for treatment in place. I understand that I may revoke this consent at any time, in writing; however, if I choose to revoke my consent for treatment, Axis will immediately discontinue providing services. Also, by signing, you are confirming that you have read or have access to the documents above.

Patient or Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient name (please print): \_\_\_\_\_

Legal Guardian name (please print): \_\_\_\_\_

**Please note the following regarding treatment:** Axis staff will depend on statements made by the patient, information provided in patient's medical history and other information as available to evaluate a patient's condition and decide on the best treatment. Some services at Axis may be provided with telehealth equipment and involve interaction with providers who are not physically in the clinic for your appointment. These sessions are transmitted via secure, dedicated high-speed lines and are not typically: videotaped, recorded, or saved in any way. However, with your consent where applicable, we may videotape or take pictures during the interaction to assist in your diagnosis, treatment, or referral, or for the purposes of supervision, training, or quality improvement. In addition, relevant information from your visit will be documented in your medical records, just as it would be if the provider had been physically present. Your healthcare providers will discuss with you the benefits and risks of treatment. If you are unclear about your treatment or the protection of your records, please feel free to ask questions at any time.

**Please note the following regarding your records and complaints:** We are required to inform you that if you file a complaint, your records may not be maintained longer than seven years and therefore would be unavailable to review in respect to such complaints.

**Protected Access and Associated Disclosure Limitations:** There are limitations on access to patient information and disclosures that are based on the type of treatment and/or the age of the patient in question. Health information for the patient is protected differently in the following circumstances.

**Minor Patients:** Axis will not release a minor's protected health records to a parent/guardian if there is any legal action involving a determination of the best interests of the minor because the minor has a right to privileged and confidential communications in relation to that type of action, unless a valid waiver of the minor's privilege or court order is received by Axis. If a minor has consented to their own treatment, Axis, upon request from a parent or legal guardian, without the consent of the minor child, may advise the parent or legal guardian only of the services given or needed. Release of this information regarding services shall not be considered a waiver of the minor's right to privileged and confidential communications or Axis's duty of confidentiality. A parent or legal guardian may be notified without the minor's consent if, based on professional opinion, the minor is unable to manage his or her care or treatment and a parent or legal guardian will be notified any time a minor expresses safety concerns, including intent to harm self or others.

## **Telehealth Patient Informed Consent and Expectations**

To participate in a telehealth service using an audio and/or visual software, as an Axis patient you must give your consent and understand Axis expectations.

### **Privacy**

Telehealth is a service delivered using electronic information and communication technologies (such as video conference, smart phone application or in this time of emergency a telephone conversation) by a healthcare provider to deliver services to an individual when he/she is located at a different site than the provider. Privacy laws that protect health information also apply to this type of visit. Axis complies with all federally required HIPAA and 42 CFR Part 2 regulations and Office of Civil Rights guidance related to these services offered through telehealth methods. Axis uses HIPAA compliant software for telehealth services.

### **I understand that during a Telehealth Service:**

- 1) Details of my medical history, including x-rays, test results, etc., will be discussed and a physical examination may take place.
- 2) Video, audio, or pictures may be taken with my consent to assist in my diagnosis, treatment, or referral, or for purposes of supervision, training, or quality improvement.
- 3) I will have the opportunity to discuss with the provider any risks, consequences, and benefits of using telehealth services as well as consult with any proposed treatment or procedure.

### **As a patient I understand that I have the right to:**

- 1) Withhold my consent to the use of telehealth services during my care at any time, without affecting my right to future care or treatment.
- 2) Revoke my consent orally or in writing at any time by contacting my provider. If this consent is in force and has not been revoked my AHS

Provider may provide telehealth services to me.

3) Access any of my protected health information provided during these services.

**As a patient I understand that Axis expects:**

- 1) That I am responsible for maintaining confidentiality for anything heard during this session and not share with any person other than my provider. It is my responsibility to ensure that the location in which I am receiving these services is secure to ensure others may not overhear what is being said, and that the session can be conducted free from distractions, or inappropriate activities.
- 2) That the space in which I am receiving these telehealth services must be in a private and confidential setting and whenever possible, in a room with only myself present.
- 3) That when connecting to the session I should be using headphones, if possible, to avoid any unintended disclosure of protected health information to others who may be present near me.
- 4) That I may not share the device screen with any other person and position it in a way that others cannot observe it.
- 5) That I may not take any screen shots or audio or video-record any sessions, however the provider may for the purposes described above.
- 6) That, if necessary, when I am not speaking it is best to mute my phone or computer audio to minimize background noise.
- 7) That I come to the session with the same expectations as if the session occurred in person, including wearing appropriate attire.
- 8) That if I fail to adhere to these expectations, I understand the session may be discontinued.

I hereby consent to Axis providing telehealth services to me in the event I wish to receive them and they are available.

Patient or Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient name (please print): \_\_\_\_\_

Legal Guardian name (please print): \_\_\_\_\_

## **FINANCIAL AGREEMENT**

### **PATIENTS WITH INSURANCE:**

It is important that you understand the benefits and limitations of your insurance coverage. Insurance coverage is not a guarantee of insurance payment. Please contact your insurance company for more information about your financial responsibility under your plan.

Axis requires your benefits be assigned to Axis so Axis can be paid directly by the insurance company and release records solely for the purposes of payment. Axis participates in Medicare, Medicaid, CHP+ and other public or private insurance programs. We employ qualified professionals; some professionals may not be contracted by your insurance company due to contractual requirements. When this occurs, your insurance company may not pay for services. Your insurance may pay a portion of the claim; however, you are ultimately responsible for the payment of services received. Axis will mail a statement of your balance due each month; payment is due within 30 days. You may receive separate statements for different types of services rendered in our clinics. If you receive laboratory services as part of a visit, your insurance may not cover the charge from our laboratory vendor; however, you may be eligible for our Sliding Fee Discount Program, and lab fees may be discounted. If you have questions about our Sliding Fee Discount Program, eligibility or application please contact your clinic location front desk staff. You have the right to opt out of having your insurance billed. If you have any questions regarding opting out and/or your statement, please email our Billing Department at [billing@axishealthsystem.org](mailto:billing@axishealthsystem.org).

### **INFORMATION SECURITY:**

Your personal information is secure with AHS. AHS uses this information for providing services, filing claims and identification/communication as it relates to healthcare operations. We

are required to obtain demographic information which includes your social security number. Refusal to provide information may constitute a refusal of service.

**SUBSTANCE USE DISORDER (SUD) PART 2 PROGRAMS ONLY:**

To bill your insurance for SUD services (in Part 2 Programs) you must disclose to your insurance that you are receiving these services by completing the Patient Consent for Axis Health System Use and Disclosure of Protected Health Information. You understand that you have the option to not have Axis bill your insurance which means you will assume all financial responsibility for the payment of all treatment that occurs within Axis, may affect all specialties, based on your stated income. You have the option to independently submit billing statements to your insurance, and you can consult with an Axis billing specialist if needed for support.

**ACKNOWLEDGE AND AGREE TO PAY:**

By signing below, you acknowledge your responsibility to pay for any services rendered by Axis. You also acknowledge your understanding that you may be billed for multiple services on the same day if you received both behavioral health, primary care, and dental services. Axis reserves the right to limit, reschedule, or refuse treatment to anyone who cannot pay at the time of service. For your convenience we accept cash, check, or credit card as payment.

**Authorize the Assignment of Benefits:** Assign all medical benefits under my coverage to Axis for services provided to me. Furthermore, my signature authorizes and directs my insurance carrier(s), including Medicare, private insurance, and any other health plan to issue payment directly to Axis for services rendered.

**Agree to my Financial Responsibility:** Acknowledge and understand that my insurance co-payments are due at the time of service, and I am responsible for any amounts that are not covered by my insurance, which may include co-insurances, deductibles or claims denied due to contracting. You are responsible for any balance due regardless of insurance coverage. If any account becomes past due, Axis reserves the right to collect on these balances prior to scheduling any future appointments. Past due amounts may involve a collection agency with the additional cost of attorney fees, court cost and any other miscellaneous fees that may be added to patient or guarantor's balance.

I understand and agree to abide by the above as it relates to my financial obligations as a patient.

Patient or Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient name (please print): \_\_\_\_\_

Legal Guardian name (please print): \_\_\_\_\_