SWOPE HEALTH SERVICES℠

**REGISTRATION FORM**

**(Please Print)**

| **PATIENT INFORMATION** | | | | | |
|---|---|---|---|---|---|
| **Last Name:** **First Name:** **Middle Initial:** | | | **Social Security Number:** | **Birth Date:** | **Sex:** ☐M ☐ F |
| **Street Address:** | **City** | **State,** | **Zip:** | **County:** | |
| **Mailing Address:** ☐Same as above | | | | **Leave a message:** ☐ Home Phone Number ☐ Cell Phone Number | |
| **Email Address:** | **Home Phone Number:** | | **Cell Phone Number:** | **Work Phone Number:** | |
| **Marital Status:** ☐Divorce ☐Married ☐Single ☐Separated ☐Widow | **Preferred Pharmacy:** | | | **Homeless Status:** ☐ Transitional ☐Doubling Up ☐ Homeless Shelter ☐ Other ☐Homeless ☐Seasonal ☐Migrant | |
| **Race:** ☐Asian ☐ American Indian/Alaskan Native ☐Black or African American ☐White ☐ Native Hawaiian ☐Pacific Islander ☐Unreported/Refused to Report | | | | **Primary Language:** _____ **Translator:** ☐Yes ☐No | |
| **Ethnicity** ***(choose only one):*** ☐Hispanic/Latino ☐Not Hispanic ☐Refused to report | | | | **Veteran Status** (***choose only one):*** ☐Yes ☐No | |
| **Employer Name :** | **Employer Status:** ☐Full Time ☐Part Time | | **Student:** ☐Yes ☐No | **Student Status:** ☐Full Time ☐Part Time | |
| **Primary Care Provider (PCP) Name:** | | | | | |
| **Does the patient have any problems with:** ☐Vision ☐Hearing ☐Reading ☐Speaking **Explain:** | | | | | |
| **Parent/Guardian OR Responsible Party Name:** | **Address:** ☐Same as above | | | **Phone Number:** ( ) | |
| **Parent/Guardian OR Responsible Party SSN:** | | **Birth Date:** | | **Relationship:** | |
| **Housing (Check One):** ☐Own ☐Rent ☐Public Assisted ☐Friend **Other:**_____ | | | | | |

| **MEDICAL INSURANCE INFORMATION** | | | | | |
|---|---|---|---|---|---|
| **(Please give your insurance card to the Patient Service Representative)** | | | | | |
| **Person responsible for bill:** | **Birth date:** | **Address (if different):** | | **Primary Phone Number:** ( ) | |
| **Occupation:** | **Employer:** | | | **Employer Phone Number:** | |
| **Patients relationship to subscriber:** ☐Self ☐Spouse ☐Child ☐Step Child ☐Other | | | | | |
| **Primary Medical Insurance:** | ☐Medicare | ☐Medicaid | ☐Blue Cross Blue Shield | ☐Other: | |
| **Subscriber's Name:** | **Birth Date:** | | **Policy #:** | **Group #:** | **Co-Payment: $** |
| **Name of Secondary Medical Insurance (if applicable):** | **Subscriber's Name:** | | **Birth Date:** | **Policy #:** **Group #:** | |

| **IN CASE OF EMERGENCY** | | |
|---|---|---|
| **Name of local friend or relative:** | **Relationship to patient:** | **Primary Phone Number** |

**Signature:** **Date:**

SWOPE HEALTH SERVICES

**GENERAL CONSENT FOR DIAGNOSIS AND TREATMENT**
**UPON REGISTRATION AND FINANCIAL RESPONSIBILITY**

I hereby certify that I have not knowingly withheld any information or income or other financial resources and the amounts I have disclosed are true and correct to the best of my knowledge.

The undersigned patient and/or responsible person or relative having registered at Swope Health services for the purposes of obtaining health services, do hereby, voluntarily consent to such diagnostic and treatment services, as might be provided by or at the direction of a physician, dentist, other health care professional or other qualified member of the staff of the Swope Health Services to me according to his/her judgment.

I recognize that I have the right to refuse any specific diagnostic or treatment service without jeopardizing my right to receive health services at the Center.

I recognize that I will be asked to sign a specific consent for surgical and other special procedures including general and/or extensive local anesthesia.

I am aware that health services are not based on an exact science, and I acknowledge that no guarantees have been made to me as to the results of any treatment services,

I hereby authorize Swope Health Services to retain, preserve and use for scientific or teaching purposes or dispose of at their convenience any specimen or tissue taken from my body during my treatment.

I hereby authorize payment of health insurance benefits recorded on the registration form to be paid directly to Swope Health Services for services provided.

I hereby authorize the Swope Health Services to furnish such information from my medical record pertaining to any and all treatment as requested by either health insurance plans or companies, if applicable to my case.

This form has been fully explained to me, and I certify that I understand its contents. **This file is to be updated in thirty days or one year which ever applies.**

I understand the charges for which I am responsible will reflect the balance due after credit for all appropriate discounts and all collections received by Swope Health Services from health insurance benefits for the above named individuals.

❑Medicare ❑Medicaid ❑Managed Care Plans ❑Mental Health ❑Homeless ❑Other (Specify) _____

**I agree to pay these charges on the day that the services are provided, within 10 days of receipt of the statement from Swope Health Services or by some other payment arrangement agreed to by Swope Health Services Patient Relations Office, telephone 816-923-5800**

*** Knowingly concealing, failing to disclose, or providing false information with the intent to receive benefits that you are not entitled may result in prosecution, disbarment from Medicaid, Medicare and any other Government funded programs**

_____ _____
**Patient/Parent/Legal Guardian Signature** **Date**

_____ _____
**Witness** **Date**

I, the patient wish to authorize release of information about any claim upon its request to another organization which provides health insurance for me, or my State Medical assistance agency and/or to the Department of Mental Health.

_____ _____
Patient/Parent/Legal Guardian Date

**CONFIRMATION OF RECEIVING PATIENT BILL OF RIGHTS**

I have received a brochure about the services offered at Swope Health Services. Inside of which is a copy of Swope Health Services "Patient Bill of Rights." After reading this document, I have had a chance to ask questions and I believe I understand what the Patient Bill of Rights means, what I might expect from this health care facility and what is expected of me and my family member(s) as registered patients here.

_____ _____ _____
Patient/Parent/Legal Guardian Signature Date Interviewer Initial

**SELF-DECLARATION OF INCOME FORM** **Guarantor's account#** _____

**I, _____ certify that my current annual household income is $_____ and my family size is _____. I declare that all of my dependents are 18 years old and younger or disabled. I understand that this self-declaration is good for 30 days only. To receive a discount on services for a 12 month period, I will need to provide proof of my income by_____.**

❑ I decline to participate in the sliding fee discount program.

**Guarantor Signature**_____ **Date**_____

**Witnessed By**_____ **Date**_____

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**Swope Health Services Registration (Please Print)**

Name: _____

DOB: _____

About Our Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

We are required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

Patient Acknowledgment of Receipt

I, _____ , hereby acknowledge that I have received a Copy of the Notice of Privacy Practices.

_____

Patient's Signature Date

_____

Signature of Parent or Patient's Representative (if applicable)

_____

Description of Legal Authority to act on Behalf of Patient

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# Agreement to Keep Scheduled Appointments

Facility Name:
Facility Address:

Facility Phone:

Patient Name: _____

Date of Birth: _____

The purpose of this Agreement is to give information about missed appointments. Missed appointments are a problem for your provider's schedule and often keep patients from getting timely medical care. We want to make sure you are aware of our policy on missed appointments.

I understand that a missed appointment is one that I do not keep.

I understand that I need to provide at least one day notice when I can't keep my appointments; however, when this is not possible, any advance notice is helpful.

I understand that if I miss three (3) appointments in a row in a 12-month's period without giving some notice before the appointment; I may only be allowed to receive services on a walk-in basis.

I understand that if things happen beyond my control and advance notice cannot be given the clinic should be called as soon as I am able to show my wish to stay with the clinic as a patient.

I understand and agree to follow the missed appointment policy.

| | |
|---|---|
| _____ | _____ |
| Patient | Date |
| _____ | _____ |
| Swope Health Services, Witness | Date |

SWOPE HEALTH SERVICES

# SWOPE HEALTH SERVICES

**3801 Blue Parkway**
**Kansas City, MO. 64130**
**(816)923-5800 FAX: (816) 922-7682**

## Authorization for Release of Protected Health Information

*To be completed by the patient or the patient's authorized representative:*

*Patient's Name* _____ *Date of Birth:*

*Street Address*

*City* *State* *Zip Code*

_____

*Telephone* *Fax*

## I hereby authorize:

☐ Swope Health Services, **OR**

☐ _____

*Name of Physician or Provider*

_____

*Street Address*

_____

*City* *State* *Zip Code*

_____

*Telephone* *Fax*

## To release my confidential health information, as described below, to: ☐ me

☐ Swope Health Services, **or**

☐ _____

*Name*

_____

*Organization Name*

_____

*Street Address*

_____

*City* *State* *Zip Code*

_____

*Telephone* *Fax*

☐ copies by mail ☐ inspection

☐ copies by fax ☐ other: _____

☐ copies to be picked-up

## For the following purpose(s):

- *If for marketing purposes, indicate whether the marketing involves direct or indirect payment to Swope Health Services.*
- *If requested by the patient, a statement "at the request of patient" is sufficient.*

_____

_____

_____

## My authorization is for the use and disclosure of the following records:

___ Statements of charges and payments
___ Diagnosis/treatment of medical illness and records of medical examinations
___ Mental health records
___ Dental records
___ Evaluation and treatment records related to alcohol and/or drug abuse.
___ X-rays and other images
___ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) information
___ Other: _____
___ All of the above

## My authorization pertains to information generated on the following date(s) or in the following time period:

_____

___

## My authorization is given freely with the understanding that:

- I may refuse to sign this authorization.
- I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing.
- Swope Health Services may not condition my treatment on my provision of this authorization.
- This authorization is valid for a thirty (30) day period from the date it is signed or sooner if so specified by me, as indicated below.
- A photocopy or fax of this authorization is as valid as the original.
- Swope Health Services, its directors, officers, employees, agents and volunteers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I will be given a copy of this signed authorization if the authorization is at the request of Swope Health Services.

## This authorization will expire on: _____

_____
Patient's Signature Date

_____
Signature of Parent or Personal Representative Date

_____
Name of Parent or Personal Representative (please print)

_____
Description of Legal Authority to Act on Behalf of Patient

_____
Witness Signature Date

SWOPE HEALTH SERVICES

# Sliding Fee Discount Eligibility Form

It may be necessary to ask some personal questions in order to determine eligibility for a discount on medical, dental or pharmaceutical charges. This information is private and confidential and will be kept on file at Swope Health Services. Income verification is determined once a year and requires proof of income and Proof of address documents to be return to Swope Health Services. (Family size and annual gross household income will be used to calculate discount and level of payment.)

List other Household Members 19 years of age and older that live with you.

| | Name | DOB | Relationship |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |

List other Household Members 18 years of age and younger or disabled that live with you.

| | Name | DOB | Relationship |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |

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Do you have any wage income from any of the following household members:

| | Sources | Hourly Rate | Hours Worked | Bi-weekly Income | Hours worked |
|---|---|---|---|---|---|
| | You | | | | |
| | Your Spouse or Significant Other | | | | |
| | Other persons (Please List) | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Do you have any income from any of the following sources and if so, how much per month?

| | Sources | You | Your Spouse | Your Children | Other Persons | Total Sources |
|---|---|---|---|---|---|---|
| | Social Security | | | | | |
| | Public Assistance | | | | | |
| | Retirement Pension | | | | | |
| | Rental Income | | | | | |
| | Interest Income | | | | | |
| | Child Support - Alimony | | | | | |
| | Other (Specify) | | | | | |
| | | | | | | |

**The sliding fee discount program has been explained to me, and I acknowledge that deliberately providing false or incomplete information in regard to determining the level of sliding fee scale discount can disqualify me or family members from being eligible for this program.**

**Guarantor Signature**_____ **Date**_____

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**PROOF OF INCOME DOCUMENTS**

The following documents can be used to meet the proof of income

- Current Payroll Check Stub. If the check stub is handwritten or does not display hours worked or hourly rate, please provide a notarized letter (on company letterhead if possible) from your employer stating: Your work hours, gross pay and hourly rate of pay.
- Current Unemployment Determination letter with benefit amount from the Unemployment Office (Phone MO 816/889-3101 or KS 913/596-3500 and give Social Security information to file claim).
- Copies of your Current Social Security, Pension, Trust, SSI Disability Award Letter or Child Support Check (Social Security Website: www.socialsecurity.gov).
- Current Financial Aid papers. Scholarships, Pell Grants, I20 etc.
- Tax profit and loss for the year
- W2 forms

**PROOF OF ADDRESS DOCUMENTS**

- Current Mail addressed to you or your spouse. Please ensure the mail includes a postmark on the outside of the envelope that is less than 30 days old. If necessary, mail yourself something. Unfortunately, we cannot accept mail sent to a PO Box.

**PLEASE ENSURE YOU RETURN ALL THE INFORMATION AT THE SAME TIME**

I understand if I do not provide the above information within **thirty (30) days** from today, I will be fully responsible for all services rendered and these services will be billed at the full price until information is returned.

**You may return requested information Monday through Friday from 8:00am to 4:30pm.**

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**STEPS TO FILE AN UNEMPLOYMENT DETERMINATION CLAIM**

1. Call 816/889-3101 Missouri or 913/596-3500 Kansas
2. Press 1 to file claim
3. Enter social security number
4. Press 1
5. Select your Pin Number (This is a number you make up)
6. Press 1 for YES and 9 for NO
7. Press 1 to File by Phone
8. Follow Instructions for Address and Zip Code
9. Remain on the phone until you speak with a representative (Do not hang up)
10. Tell the representative you need the form letter showing you are either the insured or uninsured worker

The representative will mail you a Benefits Determination Letter

SWOPE HEALTH SERVICES

# Consent for Care in Absence of Parent /Guardian

I, _____ give permission for
(PRINT Full Name of Parent or Guardian)

the following adults or caregivers:

_____ and/or _____
(Print Full Name) (Print Full Name)

to accompany and consent for any medical examination or treatment for my child or children listed below in my absence:

_____ _____/_____/_____
(Full name) (Date of Birth)

_____ _____/_____/_____
(Full name) (Date of Birth)

_____ _____/_____/_____
(Full name) (Date of Birth)

_____ _____/_____/_____
(Full name) (Date of Birth)

**I understand that it is my responsibility to inform the above mentioned adult(s) to present with a government issued picture identification [green card, visa, State ID, passport, driver's license] or employee picture identification when obtaining care for my children. Furthermore, I understand that this consent expires on _____, and must be renewed annually thereafter**
Date

_____ _____
Signature of Parent or Guardian Date

_____ _____
Witness Signature Date

**Form# 03012** **Rev: 10/04/2012**