Patient Registration

LEGAL FIRST NAME:_____ MI:_____LAST:_____Preferred Name:_____

Marital status: M / S / D /W **Sex:** M / F /T/Other____ SSN:_____DOB:_____

Mailing Address:_____City/State:_____Zip Code:_____

Physical Address:_____City/State:_____Zip Code:_____

Email:_____Primary Phone#_____Secondary/Message#:_____

Language:_____Race:_____ Hispanic/Latino **OR** Non Hispanic/Latino

Native American/Alaskan Native: Y / N Enrolled? Y / N Enrollment#:_____ Tribe:_____

PLEASE PRESENT PHOTO IDENTIFICATION, CURRENT INSURANCE CARD AND CIB (CERTIFICATE OF INDIAN BLOOD) IF ENROLLED.

In Case of Emergency Contact: Name:_____Number:_____

****Responsible Party Information –*MUST BE COMPLETED*****

- **Responsible Party information is same as above**

Parent/Guardian: First Name:_____MI:_____Last:_____

Mailing Address:_____City/State:_____Zip Code:_____

Primary Phone #_____Secondary/Message#:_____Email:_____

Relationship to Patient: Mother/ Father/ Guardian/ Self DOB:_____SSN:_____

Primary Insurance

Insurance Company:_____ ID#:_____Group Name/Number:_____

Subscriber Name:_____DOB:_____ Relationship to Patient: Guardian/ Self /Spouse

Secondary Insurance

Insurance Company:_____ ID#:_____Group Name/Number:_____

Subscriber Name:_____DOB:_____ Relationship to Patient: Guardian/ Self /Spouse

Turn over for Clinic Policies and Consent

1. CANCELLATION/NO-SHOW POLICY

Due to the limited time slots available for clinic appointments, it is important all patients attend their SCHEDULED appointments. If you are unable to attend, we ask that you call and inform the Camas Center Clinic at least 1 day prior to your appointment. If you do not cancel at least 24 hours prior to your scheduled appointment, arrive more than 10 minutes late, or do not show for your appointment, this is considered a "No-Show" As a policy, if you have more than 3 No-Shows, we reserve the right to discontinue services until a consult between you and your provider can be scheduled. Thank you for your understanding in this matter.

I HAVE READ AND UNDERSTOOD THE ABOVE POLICIES

Signature:_____ Date:_____

2. PATIENT AUTHORIZATION FOR COMMUNICATION OF INFORMATION

Camas Center Clinic is committed to privacy and confidentiality. Your medical information will be kept confidential to the degree required under existing law and regulations. However, from time to time we may need to contact you at home or work. If we need to contact you, may we have your permission to leave a message in regard to your care, any lab results, and appointment information, if you are unavailable or do not answer the phone?
I authorize/request Camas Center Clinic to:

{ } YES { } NO Leave a message on my cell phone?

{ } YES { } NO Leave a general (non-detailed) message at my place of employment?

{ } YES { } NO Leave a message with individuals in my household?

If Yes, Please indicate with whom we may leave a message:
Name:_____Relationship:_____
Name:_____Relationship:_____

3. ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

The HIPAA Privacy Rule was developed to protect the confidentiality of Individually Identifiable health information and other personal information. The Health Insurance Portability and Accountability Act (HIPAA) is a federal law. The notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. The privacy of your medical information is important to us.

We will use your Protected Health Information in the following ways:

~ For treatment purposes at the Camas Center Clinic and to/from referring Medical, Dental and Mental Health Providers
~ For Payment processes related to insurance claims and collection
~ For operations such as treatment alternatives, appointment reminders, and to conduct our day to day business and service operations

Please read a complete copy of our Notice of Privacy Practices:
If you have any questions, concerns or complaints please contact:
The Camas Center Clinic HIPAA Privacy Officer (509) 447-7111

4. FINANCIAL POLICY

Thank you for selecting Camas Center Clinic for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. I authorize my insurance benefits be paid directly to the Camas Center Clinic, **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE.** I also authorize Camas Center Clinic or Insurance Company to release any information required to process my claims.
I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I HAVE READ AND UNDERSTOOD THE ABOVE FINANCIAL POLICY

Signature:_____ Date:_____