RURAL HEALTH MEDICAL PROGRAM, INC.
*Providing Quality Healthcare Services Since 1977.*

# PATIENT ENROLLMENT/ REGISTRATION FORM

*Please complete the following information and return to the Receptionist.*

PATIENT NAME: _____

SEX AT BIRTH: ☐ Male ☐ Female BIRTHDATE: _____/_____/_____ SSN: _____-_____-_____

PATIENT ADDRESS: _____ APT # _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL NUMBER: _____

EMAIL: _____

PREFERRED METHOD OF COMMUNICATION: ☐ Telephone ☐ E-mail (Patient Portal) ☐ US mail

PATIENT EMPLOYER: _____ OCCUPATION: _____ PHONE: _____

EMERGENCY CONTACT: _____ RELATION TO PATIENT: _____ PHONE: _____

**Preferred Language**
- ☐ English
- ☐ Spanish
- ☐ Signing/ASL
- ☐ Other_____

**Ethnicity (check one)**
- ☐ Hispanic of Latino
- ☐ Not Hispanic or Latino

**Race**
- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ American Indian/Alaska Native
- ☐ Other_____
- ☐ More than one race
- ☐ Chose Not to Disclose

**Marital Status**
- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced

**Veteran Status**
- ☐ Active Duty
- ☐ Discharged (Veteran)
- ☐ National Guard
- ☐ Reserves
- ☐ None

**Preferred Pharmacy**
- ☐ RHMPI
- ☐ OTHER_____

**School Based Health Care**
- ☐ Yes
- ☐ No

**Sexual Orientation**
- ☐ Straight/Heterosexual
- ☐ Lesbian or Gay/Homosexual
- ☐ Bisexual
- ☐ Something Else
- ☐ Don't Know
- ☐ Chose Not to Disclose

**In Public Housing**
- ☐ No
- ☐ Yes

**Farmer Worker Status**
- ☐ Migratory Farm Worker
- ☐ Seasonal Farm Worker
- ☐ Not Applicable

**Gender Identity**
- ☐ Male
- ☐ Female
- ☐ Transgender Male/Female-to Male
- ☐ Transgender Female/Male-to-Female
- ☐ Other
- ☐ Chose Not to Disclose

**Are you living:**
- ☐ Doubled Up (Living with Others)
- ☐ In a Homeless Shelter
- ☐ On the Street
- ☐ Transitional Housing
- ☐ Not Applicable

**How did you learn about RHMPI?**
- ☐ Radio ☐ Television ☐ Newspaper
- ☐ Website ☐ Friend ☐ Health Fair
- ☐ Doctor ☐ RHMPI Employee
- ☐ Social Media (e.g., Facebook, Twitter, Instagram, YouTube, etc.)
- ☐ Other _____

***Income Information***

***(Please complete if you wish to qualify for discounts on service)***

**What is your monthly household income?** _____

**How many people are in your household?** _____

## INSURANCE & BILLING INFORMATION

Do you have Medicare? ☐ No ☐ Yes (*If Yes, No.*_____) Do you have Medicaid? ☐ No ☐ Yes If Yes, No._____

Do you have commercial insurance? ☐ No ☐ Yes (*If Yes, List Below)*

_____

*Primary Insurance Company Name* *Policy#* *Group#* *Effective Date* *Policy Holder* *DOB of Policy Holder*

_____

*Secondary Insurance Company Name* *Policy#* *Group#* *Effective Date* *Policy Holder* *DOB of Policy Holder*

***Person Responsible for Payment of Account***

NAME: _____ BIRTHDATE: ____/____/____ SOCIAL SECURITY NUMBER: _____-_____-_____

RELATIONSHIP TO PATIENT: SELF_____ PARENT _____ CHILD _____ OTHER _____

SIGN THESE FORMS AND RETURN TO RECEPTIONIST

## *GENERAL CONSENT TO TREAT AND ACKNOWLEDGEMENT OF TEACHING SERVICES*

I hereby consent to any and all treatment that my Rural Health Medical Program, Inc. (hereinafter "RHMPI") clinician and I agree is necessary for me or for the patient(s) I am guardian for. I understand and acknowledge that RHMPI is a teaching center, and my care, and/or the care of patients(s) I am guardian for, at RHMPI may be provided by a clinician, including but not limited to medical students and/or resident physicians and/or resident dentists, in a clinical training program. I further understand and acknowledge that teaching services such as direct observation by other physicians or medical students, case discussions, or photographic or video images of care activities involving myself or my dependents are allowed for teaching purposes unless specifically denied by me. I further understand that as part of its health care services, RHMPI's personnel and my clinician may create and maintain a record of care and services provided. I understand that such information may be used and/or disclosed in the management and delivery of care and services provided by RHMPI, as described in the Notice of Privacy Practices. I understand and acknowledge that RHMPI participates in an electronic health record exchange program, and that if I seek treatment from other healthcare facilities or providers participating in this exchange program, my health information, or that of the patient(s) I am guardian for, may be shared between RHMPI and those other facilities or providers. I understand and acknowledge that as part of receiving my healthcare at RHMPI, RHMPI's clinicians and other personnel may electronically request and/or provide health records for me and/or patient(s) I am guardian for, to those participating facilities or providers. These records include, but are not limited to prescription medication history, as well as information related to mental health treatment, alcohol and/or drug abuse diagnosis, prognosis and treatment, and/or HIV (AIDS) testing/results and/or treatment. I further understand that any such information from any source whatsoever may become part of the requesting party's health records on me and/or the patient(s) I am guardian for.

## *NOTICE OF PRIVACY PRACTICES*

I hereby understand that I have the right to request a copy of the Rural Health Medical Program's Notice of Privacy Practices.

## *LIMITED ENGLISH PROFICIENCY*

The Rural Health Medical Program, Inc. proudly offers certain language assistance to its patients free of charge. We also strive to make reasonable accommodations for our patients with disabilities.

***SIGNATURE:*** _____

*(Patient, Parent or Guardian)*

***Date:*** _____

## *PHOTOGRAPHY & VIDEO SURVEILLANCE*

I consent to the taking of photographic and/or video images for the purpose of identification and documentation of my medical care. I hereby authorize the use of video surveillance cameras for the purpose of ensuring the safety and security of patients and staff. I understand that images may be recorded for review. I give RHMPI the absolute and irrevocable right and permission to use video tape devices to monitor the facilities.

## *STATEMENT OF FINANCIAL RESPONSIBILITY*

I hereby understand I am the person primarily responsible for payment of all charges for services rendered by RHMPI, regardless of any insurance coverage I might have, including Medicare or Medicaid, and that such payment is due at the time of service unless definite financial arrangements have been made prior to treatment. I further understand that in addition to such service charges and out-of-pocket costs (e.g., eyeglasses, injections, prescription drugs, dentures, etc.), I will be liable for any court costs, attorney's fees, collection expense, or interest that may be incurred should such actions be required to obtain payment for services rendered by RHMPI. This consent authorization applies to the initial and all subsequent visits, unless revoked by me in writing. I certify that the patient and financial information given at the time of services rendered is accurate and complete.

## *ASSIGNMENT OF INSURANCE BENEFITS*

In consideration of service rendered, I hereby irrevocably assign and transfer to RHMPI, all rights, title and interest in benefits payable for services rendered by RHMPI. I hereby authorize and instruct the insurance company (including but not limited to Medicaid, Medicare, and commercial carriers), to pay directly to RHMPI all benefits due under the terms of my policy or policies. I will pay RHMPI for all non-covered charges or for all legally allowed charges in excess of whatever sums may be paid by the insurance company.

## *MEDICAID/MEDICARE ACKNOWLEDGMENT*

I have been informed by a RHMPI healthcare provider that some services/items I request, including those provided to me on _____ (*today's date*), may not be covered under the Medicaid and/or Medicare Programs as being reasonable and medically necessary for my care. I understand that the Medicaid and/or Medicare Programs, or their health-insuring agent(s), determine the medical necessity of services/items I request and receive. I also understand that I am responsible for payment of services or items I request and receive if these services/items are determined by Medicaid and/or Medicare not to be reasonable and medically necessary for my care.

***SIGNATURE:*** _____

*(Patient, Parent or Guardian)*

***Date***: _____

## *LABORATORY FEES*

I, the undersigned understand that there is a fee for laboratory tests ordered by the attending provider. I also understand that I may receive an additional fee from an outside lab. I will talk to the provider about any questions before any test is ordered on my behalf.

***SIGNATURE***: _____ *DATE:* _____
*(Patient, Parent or Guardian)*

*WITNESS:* _____ *DATE:* _____

## *TELEMEDICINE*

CONSENT FOR TELEMEDICINE CONSULTATION: By signing in this section, you are consenting to participate in telemedicine consultation services. You are acknowledging that you have read and understand the provisions for telemedicine. You are acknowledging that your health care provider has explained to you how telemedicine video conferencing works.

***I hereby consent to participation in a telemedicine consultation.***

***SIGNATURE***: _____ *DATE:* _____
*(Patient, Parent or Guardian)*

*WITNESS:* _____ *DATE:* _____

## *MEDICATION HISTORY*

I hereby authorize RHMPI, access to my medication history and all prescriptions filled at pharmacies within the state of Alabama.

***SIGNATURE***: _____ *DATE:* _____
*(Patient, Parent or Guardian)*

*WITNESS:* _____ *DATE:* _____

## *PATIENT'S RIGHTS AND RESPONSIBILITIES*

I, the undersigned, understand have been informed of the Patient's Rights and Responsibilities of Rural Health Medical Program, Inc., and offered a copy.

***SIGNATURE***: _____ *DATE:* _____
*(Patient, Parent or Guardian)*

*WITNESS:* _____ *DATE:* _____

RURAL HEALTH
MEDICAL PROGRAM, INC.
*Providing Quality Healthcare Services Since 1977.*

# Authorization to Access Information

I _____,
(Printed Name & Date of Birth)

hereby authorize Rural Health Medical Program, Inc. staff to disclose any and all of my health information to the following individual(s) until further notice is given.

| | |
|---|---|
| _____ | _____ |
| (Name) | (Relationship) |
| _____ | _____ |
| (Name) | (Relationship) |
| _____ | _____ |
| (Name) | (Relationship) |
| _____ | _____ |
| **(Patient Signature)** | **Date** |

***For Clinic Use Only:***

Appropriate identification has been presented and verified.

Name of staff member/department: _____

Clinic Name:_____ Date:_____

# AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

*Rural Health Medical Program, Inc. ○ 101 Park Place ○ Selma, AL 36701*

Patient Name: _____ Date of Birth: _____ SS #: _____

Address: _____ Apt # _____ City: _____ State: _____ Zip Code: _____

**Obtain Information From:**

Name: _____
Address: _____
City: _____ State: _____ Zip Code_____
Ph #: _____ Fax #: _____

**Release Information To:**

Name: _____
Address: _____
City: _____ State: _____ Zip Code_____
Ph #: _____ Fax #: _____

**PATIENT INFORMATION IS NEEDED FOR THE FOLLOWING:**

☐ Transfer Care ☐ Treatment ☐ Insurance ☐ SS Disability

☐ Legal Purposes ☐ School/Daycare ☐ Personal Use ☐ Other, please specify _____

Dates of Treatment: _____

**Information to Be Used and/or Disclosed:**

☐ Face Sheet ☐ History and Physical ☐ Office Notes ☐ Lab/Pathology Reports ☐ Operative Reports
☐ Consultation Reports ☐ X-ray Reports ☐ Other (Specify) _____

**Substance Abuse, Mental Health, HIV/AIDS**
I understand that my medical or billing records might contain information in reference to drug, alcohol, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, HIV/Aids (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome), and/or other sensitive information and I agree to this release.

_____
(Signature of Patient or Legally Authorized Representative)

**Time Limit & Right to Revoke Authorization**
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Office at ***P.O. Box 2213, Selma, AL 36702-2213.*** Unless revoked, this authorization will expire on the following date or event: _____ or one year after the date of the signing of this authorization as shown below.

**Re-Disclosure**
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

**Signature of Patient or Personal Representative Who May Request Disclosure:**
I understand that Family Health Center may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I authorize Family Health Center to use and disclose the protected health information described above.

Signature: _____ Date: _____
Patient or Legally Authorized Representative

_____ _____
Printed Name of Patient or Legally Authorized Representative Relationship to Patient

***Fees/Charges will comply with all laws and regulations applicable to release of Protected Health Information. Payment is due at the time of release.***

# MEDICAL HISTORY FORM

Patient Name: _____ Age: _____ Today's Date: _____

Date of birth: _____ PID (Office use only): _____

Reason for today's visit: _____ Date last seen: _____

Name of last primary care physician: _____ Physician's Address: _____

## Medical History - Check the Conditions YOU have ever had

- ☐ Diabetes - Type I o Type II? _____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Failure / CHF
- ☐ Heart Attack/Coronary Artery Disease
- ☐ Pacemaker/Defibrillator
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Asthma
- ☐ COPD/Emphysema/Chronic Bronchitis
- ☐ Cancer - What type? _____
- ☐ Thyroid Problems
- ☐ Peripheral Vascular Disease/Circulation problems
- ☐ Blood Clot/DVT
- ☐ Bleeding disorder
- ☐ Anemia
- ☐ Tuberculosis
- ☐ Other_____
- ☐ Hepatitis - What type? _____
- ☐ Cirrhosis/Liver Disease
- ☐ Alcoholism/Drug Addiction
- ☐ Arthritis - What type? _____
- ☐ Gout
- ☐ Osteoporosis/Thin bones
- ☐ Prostate Problem
- ☐ HIV/AIDS
- ☐ Herpes
- ☐ Other STD/Venereal Disease
- ☐ Depression
- ☐ Anxiety
- ☐ Suicide Attempt
- ☐ Other Mental Illness
- ☐ Seizure
- ☐ Paralysis
- ☐ Migraines
- ☐ Other: _____

### *WOMEN ONLY*

_____ When was your last PAP smear?
_____ Ever had an abnormal PAP?
If so, when? _____
_____ FIRST day of your last menstrual period?
_____ When was your last mammogram?
_____ Ever had an abnormal mammogram?
If so, when? _____
Yes No Are you currently pregnant?
Due date: _____
Yes No Ever had complications with your pregnancy?
If so, please explain. _____

| How many? | |
|---|---|
| _____ | Total Pregnancies |
| _____ | Live Births |
| _____ | Premature Births |
| _____ | Miscarriages |
| _____ | Abortions |
| _____ | C-Sections |
| _____ | Vaginal Birth after C-Section |

| List medications you are ALLERGIC to: | List current Medications & Doses you are taking *(Ex: Prinivil 40 mg daily)* |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

*Patient Name:* _____ PID (Office use only): _____

| Previous Surgeries | | Health Habits |
|---|---|---|
| **Date** | **Type of Surgery** | **How much of each do you use per day? (If not every day, how much per week?)** |
| | Gallbladder | Caffeine : |
| | Appendix | Alcohol |
| | Tonsils | Tobacco: |
| | Hernias | Street Drugs: |
| | Hysterectomy - ovaries removed? | |
| | Tubal Ligation (*tubes tied*) | **Occupation/Travel** |
| | Breast Biopsy | Any exposure to hazardous materials? |
| | Back Surgery | _____ |
| | Other:_____ | Travel to foreign countries? |
| | Other:_____ | _____ |

| FAMILY HISTORY: List family members with the following conditions (NOT YOURSELF) | |
|---|---|
| Diabetes | |
| High Blood Pressure | |
| High Cholesterol | |
| Heart Attacks | |
| Kidney Disease | |
| Bleeding problem | |
| Strokes | |
| Cancer (what kind?) | |
| Arthritis | |
| Asthma | |
| COPD/Lung Problems | |
| Are your parents still living?<br>If no, what was the age and cause of death? | |
| Are your siblings still living?<br>If no, what was the age and cause of death? | |

| **Symptoms:** Please check if you are experiencing any of the following | | |
|---|---|---|
| ☐ Unintentional weight loss | ☐ Chest pain | ☐ Fainting |
| ☐ Diarrhea or Vomiting | ☐ Rash | ☐ Forgetfulness |
| ☐ Blood in stools or urine | ☐ Erection problems | ☐ New headache |
| ☐ Leaking urine or stool | ☐ Vision problems | ☐ Trouble sleeping |
| ☐ Night sweats/Fevers | ☐ Too thirsty | ☐ Pain - where? _____ |
| ☐ Penile or Vaginal discharge | ☐ Constipation | ☐ Other:_____ |
| ☐ Shortness of breath | ☐ Persistent cough | |
| ☐ Swelling in feet/ankles | ☐ Suspicious lumps or bumps (where?)_____ | |
| ☐ Irregular/Painful periods | ☐ Difficulty breathing when lying down | |