Settlement Health

Chart #: ____________________

Patient Registration and Attestation Form

Patient's Name: ____ **DOB:** ___________________ **Gender** __M __F

SS#: ______________________ **Email:**_________________________________ **Pharmacy:**________________________________

Parent /Legal Guardian (Circle)*:* ____ **DOB:** ______________________________

Address: ____

Apt #

____

City **State** **Zip Code**

Home Phone: _________________________ **Work Phone** ____________________________**Cell Phone:** ______________________

Emergency Contact Name: ___________________________________**Phone:** __________________ **SH Patient:** ☐Yes ☐No

Please circle yes or no to the following questions: **Veteran?** YES NO **Insurance?** YES NO **Card?** YES NO

Please list other Household Members and children under 18 years of age who are Settlement Health patients:

				Relationship to the Above Individual	Insurance Card
NAME	DOB	____M	F	_ _Relationship________________	☐Yes ☐No
NAME	DOB	____M	F	_ _Relationship________________	☐Yes ☐No
NAME	DOB	____M	F	_ _Relationship________________	☐Yes ☐No
NAME	DOB	____M	F	_ _Relationship________________	☐Yes ☐No

☐ **ASSIGNMENT OF BENEFITS:** I authorize payment of medical benefits to be sent directly to Settlement Health Family or its individual providers for services rendered for me and all my identified children under 18 years of age as listed above.

☐ **FINANCIAL AGREEMENT:** I understand and agree that I am ultimately responsible for the balance for myself and all my identified children under 18 years of age as listed above for any professional services rendered. Should my insurance claim be denied for lack of eligibility or termination of coverage, I understand that I will be held responsible and intend to make payment for any balance due in those instances.

☐ **AUTHORIZATION OF TREATMENT:** I hereby give permission to the staff of Settlement Health to provide medical treatment, vaccine administration which is transmitted to the NYC Immunization Registry and access to prescription information from Sure Scripts and release medical information for reimbursement purposes for myself and all my identified children 18 years of age or under as listed above. My signature below indicates that I have received a copy of the PATIENT BILL OF RIGHTS and RESPONSIBILITIES as well as the HIPAA PRIVACY NOTIFICATION.

Signature of Patient/Guardian: ____ **Date**________________________

Sliding Fee Discount Program Eligibility: **(Please check all that apply):**

☐ **Attached is my income documentation– tax records, paystubs, employer letter, etc.**
☐ **I have no documentation to verify my income.** ☐ **I did not file a tax return last year.**
☐ **I get paid in cash.** ☐ **I do not get paychecks or pay stubs.** ☐ **I cannot get a letter from my employer.**

Household Income amount below (choose one box): *(Self Declaration)*

Yearly	**Monthly**	**Biweekly**	**Weekly**
$	**$**	**$**	**$**

Family size (individuals in your household that you are financially responsible for) including yourself:________________________

☐ **I am not interested in disclosing my financial information, therefore my family and I are not eligible for the sliding fee discount program.**

I certify that the above information is true and correct. I understand that this information is to be used to determine eligibility for the center's sliding fee discount program. I understand that Settlement Health may verify information on this form. I also understand that if I intentionally misrepresent my family's income, I will not be eligible to receive services at a discounted rate.

Signature of Patient/Guardian:____ **Date:**_________________ *(4/18/2018)*