WELCOME TO OUR OFFICE
Family Health Center of Southern Oklahoma

Today's Date:_____

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE PERFORMED

Thank you for choosing our office. In order to serve you properly, we will need the following information: Please print using black ink.

Patient's Last Name	First Name	M.I.	Date of Birth	Gender Assigned at Birth Male Female	Gender Patient Identifies As M F Trans male/F to M Trans Female/ M to F	Sexual Orientation Lesbian or Gay Straight Bisexual Don't Know Choose not to Disclose
Marital Status M D W S	Veteran Yes No		Employment: Full Time Part Time Unemployed Self-employed Retired US Military			
Mailing Address	City		County	State	Zip Code	
Do you live in Public Housing Y N	Home Phone	Cell or Message Phone	Are you a Student Full Time Part Time	Occupation		
E-mail Address	Social Security Number		Driver's License Number			
Name of Spouse (Parent or Guardian if Minor)	Relationship if Minor		Social Security Number	Date of Birth		
Name of Patient's Employer	Employer's Address		Work Phone			
Race (please circle) White Am Ind/Native Alaskan Black/AA Hispanic Asian Native Hawaiian Other Pacific Islander	What is your National Origin? Canada England Germany Mexico Puerto Rico Sweden US					
Primary Insurance	Insurance Claims Address (usually on back of card)		Insurance Phone			
Card Holder's Name	Card Holder's Date of Birth		Card Holder's Social Security Number			
Secondary Insurance	Insurance Claims Address (usually on back of card)		Insurance Phone			
Card Holder's Name	Card Holder's Date of Birth		Card Holder's Social Security Number			

Financial Responsibility

Responsible Party	Responsible Party's Address	
Responsible Party's Social Security Number	Responsible Party's Phone Home: Cell:	Responsible Party's Date of Birth:

How did you learn about our facility?_____

Do you live in a ___**Single** ___**Double** family home? Are you homeless? ___Yes ___No

Are you a migrant worker? ___Yes ___No

Annual Income Level: □ $0.00-$10,000 □ $10,000 - $20,000 □ $20,000 - $30,000
□ $30,000 - $40,000 □ Above $40,000

What pharmacy do you prefer to use? _____

_____ _____

Patient Signature Date

PATIENT AGREEMENTS AND ACKNOWLEDGEMENT

AUTHORIZATION FOR MEDICAL, DENTAL, OR BEHAVIORAL HEALTH TREATMENT

Family Health Center of Southern Oklahoma and its personnel are hereby authorized to administer any behavioral health, dental, medical, diagnostic or therapeutic treatment as may be deemed necessary or advisable. I represent to Family Health Center of Southern Oklahoma that I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

ASSIGNMENT OF INSURANCE BENEFITS

I agree that insurance or medical benefits for Family Health Center of Southern Oklahoma charges otherwise payable to me are to be made payable to Family Health Center of Southern Oklahoma. Any payment received for health services may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits.

PRECERTIFICATION

I understand that Family Health Center of Southern Oklahoma will assist with insurance precertification requirements which are the responsibility of the policyholder and/or physician, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

FINANCIAL RESPONSIBILITY

As consideration for the health services provided me, payment is guaranteed for any amount due for such services provided by Family Health Center of Southern Oklahoma. Charges for services and goods shall be at Family Health Center of Southern Oklahoma 's billed charges rates unless otherwise agreed to in writing byFamily Health Center of Southern Oklahoma.

CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have received a copy of the Notice of Privacy Practices and this Patient Agreement and Acknowledgement. I further certify that I am the patient or duly authorized by the patient to accept the terms of the Patient Agreement and Acknowledgement. A photocopy of this document has the same effect as an original.

DISCLOSURE OF INFORMATION

I understand that my medical records and billing information are made and retained by Family Health Center of Southern Oklahoma and are accessible to Family Health Center of Southern Oklahoma personnel as needed to perform their respective job duties. Family Health Center of Southern Oklahoma personnel in attendance may use and disclose medical information for operational purposes and to any other physician, behavioral health care provider, or other healthcare professional involved in your care or with the primary care team. Safeguards are in place to discourage improper access to my protected health information. Family Health Center of Southern Oklahoma and its personnel are authorized to disclose all or part of my medical record to any insurance carrier or health plan, workers compensation carrier, or self-insured employer group liable for any part of Family Health Center of Southern Oklahoma 's charges and to any health care provider who is or may become involved with my care. **Oklahoma law requires that we advise you that the information authorized for disclosure may include records which may indicate the presence of a communicable or noncommunicable disease.**

PHOTOGRAPHS

I agree to be photographed for identification purposes.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND CONSENT

A complete description of how your medical information will be used and disclosed by Family Health Center of Southern Oklahoma is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this agreement. A copy is available to you upon registration and is posted at Family Health Center of Southern Oklahoma.

By signing this agreement I acknowledge receipt of Family Health Center of Southern Oklahoma s Notice of Privacy Practices and authorize the use and disclosure of my medical information as described in the Notice of Privacy Practices.

Patient or Responsible Party	Relationship	Date Signed	Witness

Basis for refusal, if refused: _____

Patient Contacts & Authorization of Medical/Dental Record Release

Patient Name: ______________________________ Patient DOB: ____________________

Today's Date: _______________

Contact's First Name	Contact's Last Name		MI
Contact's Home Phone	Contact's Work Phone	Contact's Cell Phone	Contact's Fax #
Contact's E-mail		Patient Relationship to Contact	
Contact's Address		City/State/Zip	

I authorize the above named person to be my contact for the following responsibilities (check any that apply):

☐Emergency Contact ☐**Release Records** ☐Primary Contact ☐Primary Caregiver

☐Legal Guardian/Health Care Proxy ☐Patient Resides with Contact

Contact's First Name	Contact's Last Name		MI
Contact's Home Phone	Contact's Work Phone	Contact's Cell Phone	Contact's Fax #
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I hereby authorize clinic personnel to disclose medical and/or dental information on the below named patient to contacts marked "Release Records"

Patient Signature: ______________________________ Clinic Representative: ____________________________