REGISTRATION FORM

PATIENT INFORMATION

Patient Name_____ Social Security Number_____
First Middle Last

Date of Birth_____ Sex at Birth (male or female)_____

Address_____
Street City, State, Zip

Email Address_____

Home Phone Number_____

Cell Phone Number_____

Can we leave a message? ❑ Yes ❑ No

Last Grade Completed_____

Public Housing ❑Yes ❑ No

Email Address_____

Preferred Method of Contact
❑Electronic portal (via secure messaging)
❑voicemail ❑email ❑text/SMS

Ethnicity ❑Hispanic ❑Non-Hispanic ❑Decline to answer

Race ❑Black/African American ❑Caucasian (White)
❑American Indian/Alaskan Native ❑Asian
❑Native American Pacific Islander ❑Native Hawaiian
❑Multiple Races ❑Decline to answer

Gender Identity (*Check off one box only please)*
❑Male
❑Female
❑Transgender Male (Female-to-Male)
❑Transgender Female (Male to Female)
❑Other
❑Decline to answer

Sexual Orientation (*Check off one box only please)*
❑Straight
❑Gay
❑Lesbian
❑Bi-sexual
❑Other
❑I don't know
❑Decline to answer

Employer_____

Veteran ❑Yes ❑No

Country of Origin_____

Marital Status ❑Single ❑Married ❑Separated ❑Divorced ❑Widow

Language Preference_____

Name of Pharmacy_____

FOR CHILDREN

Mother/Guardian Name_____ Phone Number_____

Father/Guardian Name_____ Phone Number_____

Children live with ❑Mother ❑Father ❑Guardian

Mother's Maiden Name_____

The persons listed above may sign consent for treatment, on behalf of my child

_____ _____ _____
Patient/Guardian Signature Signature of Legal Representative Date

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Name_____ Relation to patient_____ Phone Number_____

Name_____ Relation to patient_____ Phone Number_____

Name_____ Relation to patient_____ Phone Number_____

Name_____ Relation to patient_____ Phone Number_____

Name_____ Relation to patient_____ Phone Number_____

***The persons listed above can NOT sign consent for treatment, on behalf of my child.**

IN CASE OF EMERGENCY

Emergency Contact Name_____ Phone Number_____

Relationship to patient ❑Self ❑Spouse ❑Child ❑Other (please specify)_____

FINANCIAL/INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Name of person responsible for bill_____ Date of Birth_____

Social Security Number_____ Phone Number_____

Address_____

Street City, State, Zip

Household Income $_____
❑Yr. ❑Mo. ❑Wk. ❑Bi-wkly

Number of Dependents
spouse/children under 18

Primary Insurance_____ Policy Holder Name_____ Policy Number_____

Secondary Insurance_____ Policy Holder Name_____ Policy Number_____

Patient's relationship to Insured ❑Self ❑Spouse ❑Child ❑Other (please specify)_____

Complete Below for Private Insurance Only

_____

Employer Name Employer Phone Number Group #

GENERAL CONSENT FOR TREATMENT AND PRIVACY NOTICE

The above information is true to the best of my knowledge. I hereby give Optimus Health Care and its medical providers my consent for any necessary medical evaluation and treatment.

I acknowledge that I have reviewed the Optimus Health Care

□ Notice of privacy practice
□ Failure to Keep Appointments policy and,
□ Patient Bill of Rights in the language of my understanding

I also understand that I may request another copy at any time. I authorize Optimus Health Care, Inc. or insurance company to release any information required to process my claims. I understand that I am financially responsible for any balance due, regardless of insurance or third party accommodations.

_____ _____ _____

Patient/Guardian Signature Signature of Legal Representative Date

OPTIMUS HEALTH CARE

Patient Bill of Rights

All Optimus Health Care, Inc. patients have the rights and responsibilities outlined below:

1. The patient has the right to receive complete information and confidentiality regarding their medical condition and treatment plan.
2. The patient has the right to complete information on the services and off-hour coverage system of Optimus Health Care, Inc.
3. The patient has the right to complete information regarding research projects that might include them and the right to refuse to participate in such projects.
4. The patient has the right to their complete medical records upon request.
5. The patient has the right to complete information regarding fees, charges, and reimbursement policies of Optimus Health Care, Inc.
6. The patient has the right to have treatment provided with consideration, respect, and privacy.
7. The patient has the right to be assessed for pain management and to be treated and/or referred to a specialist.
8. The patient has the right to a second opinion from a physician of their choosing.
9. The patient has the right to file a grievance requesting a resolution of their concern. The patient has the right to request changes in processes as it affects the services provided to them. The patient has the right to communicate directly with The Joint Commission (www.jointcommission.org), by which Optimus Health Care, Inc. is accredited.

Appointment Policy

To ensure access to appointments for all patients, Optimus Health Care, Inc. has the following policy regarding a patient who frequently misses their appointments:

- If you are unable to keep a scheduled appointment or call the office with less than 24 hours' notice to cancel or reschedule an appointment, each such appointment will be considered a "No Show."
- If you miss three (3) appointments within a six (6) month period, you will be considered a frequent "No Show" for future appointments.
- Patients who frequently "No Show" for appointments will be allowed to schedule future appointments only during designated health center hours.
- This policy applies to medical, dental, pediatrics, behavioral health, and OB/GYN patients.
- Optimus will continue to provide you with care during designated health center hours.

- You have the right to appeal Optimus Health Care, Inc.'s determination that you frequently "No Show" to appointments. The health center staff can guide you in beginning the appeal process, and a decision will be made within 30 days.

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 Practice provides information regarding:

- Our obligations under the law concerning your personal health information
- 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