marin community clinics
connecting for health

PATIENT REGISTRATION FORM

PLACE STICKER HERE

DEMOGRAPHICS

Name of Patient _____ _____ _____@_____
Last First Middle Previous Name Email

Social Security _____ **Date of Birth** _____/_____/_____ Age _____ Sex: ☐Female ☐Male
Month Day Year

Home Address _____ Apt._____ City _____ State _____ Zip _____

Mailing Address _____ Apt._____ City _____ State _____ Zip _____

What is the best number to contact you?
☐Home ☐Cell ☐Work ☐Alternate ☐Confidential - ***Do Not Call***

Is it okay if we can contact you via?
☐ Voice Message ☐Text ☐ Email

Home # _____ Cell #_____ Work #_____

Alternate # _____ If applies, whose phone number is this? _____

Language: ☐English ☐Spanish ☐Vietnamese ☐Other_____ **Impairments and/or Disabilities:** ☐Visually Impaired ☐Hearing Impaired

Do you have difficulty receiving our services in English? ☐Yes ☐No

EMERGENCY CONTACT

Name _____ Relationship _____ Phone #_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Life Partner ☐Widowed ☐Legally Separated

Student Status: ☐Not a Student ☐Part Time Student ☐Full Time Student

FOR MINORS ONLY:

Parent/Legal Guardian of Minor: _____ Date of Birth _____ Relationship to minor _____

Parent/Legal Guardian of Minor: _____ Date of Birth _____ Relationship to minor _____

Homeless Status: Are you homeless? ☐Yes ☐No **If yes, check one:** ☐Doubling Up ☐Shelter ☐Street ☐ Decline to state

Are you an agricultural (farm) worker? ☐Yes ☐No **Veteran Status:** Are you a Veteran? ☐Yes ☐No

If yes, please check if you are:

☐ A migrant worker (leave your community for work)
☐ Seasonal Worker (work on a seasonal basis within your home community)

Race: *(Please check one, ONLY)* ☐White ☐African American/Black ☐American Indian/Alaskan Native ☐Asian ☐More than one race
☐Native Hawaiian ☐Other Pacific Islander ☐ Decline to state

Ethnicity: *(Please check one, ONLY)* ☐Hispanic/Latino ☐Non-Hispanic/Non-Latino ☐ Decline to state

Do you currently have insurance: ☐Yes ☐No **Family Size:** _____ **Family Income:** _____

If yes: Name of Insurance: _____ Insurance #: _____

RESPONSIBLE PARTY (Guarantor) – ***Statement/bills will be addressed to responsible party.***

Name: _____ Date of Birth _____/_____/_____ _____@_____
Month Day Year Email

Mailing Address _____ Apt._____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work Phone _____

FOR OFFICE USE ONLY:

Home Clinic: ☐Greenbrae ☐Novato ☐Novato Wellness ☐San Rafael ☐San Rafael Campus Clinic

Data entered by: _____ Initials: _____ Date: _____

Please see other side.

MARIN COMMUNITY CLINICS – GENERAL MEDICAL CONSENT

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services will be provided if needed.

Consent for Treatment: I request Marin Community Clinics (MCC) to provide me with medical care. I will be given information about the test(s), treatment(s), procedure(s), and medication(s) to be provided, including the benefits, risks, possible problems/complications, and alternate choices. I understand that I should ask questions about anything I do not understand. I hereby request that a person authorized by Marin Community Clinics provide appropriate evaluation, testing, and treatment.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care.

Release of Information: I understand that confidentiality will be maintained as described in *Notice of Health Information Privacy Practices*. I consent to the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*. **I understand that all services are confidential. However in cases of life threatening emergencies and physical or sexual abuse, we may need to make a referral to another agency.**

Assignment of Insurance Benefit: I hereby authorize payment directly to MCC of benefits otherwise payable to me but not to exceed MCC's regular charges for this service. **I understand that I am financially responsible to MCC for any charges not covered by my insurance.**

Financial Agreement: I agree to pay all charges that are not payable by insurance or third party. I agree to abide by the terms and conditions of MCC's Collections Policy, and agree to pay for attorney fees or other expenses incurred in the collection of payment due.

In accordance with MCC's Collections Policy, MCC may choose to terminate its relationship with any patient who does not comply with this financial agreement.

Statement to Permit Payment of Medicare Insurance Benefits to MCC: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf.

Acceptance of Responsibility for Co-Payments: I understand that I am responsible for any health insurance deductibles or co-payments, including a twenty percent (20%) co-payment for authorized services covered by Medicare.

The undersigned certifies that he/she has read and understood the information above and authorizes services by Marin Community Clinics as the patient or as the patient's general agent and accepts its terms.

_____

Print Name

_____ _____

Signature of Patient or Legal Guardian Date Signed

_____ _____

Witness Date Signed