PATIENT REGISTRATION FORM

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Omni Family Health

First Name:	**Middle Name**:	**Last Name**:	**Date of birth**: / /

Mailing Address: (include suite, apt, etc.) **City** **State** **Zip Code**

Physical Address: (if different) **City** **State** **Zip Code**

Home Phone: ( ) -
Cellular Phone: ( ) -

For the purposes of sending you healthcare reminders and information about your healthcare, I agree to receiving: Telephone calls ○ Y ○ N Text messages ○ Y ○ N Mail correspondence ○ Y ○ N

May we contact you by e-mail? ○ Y ○ N
e-mail address:

Which language are you most comfortable using?
○ English ○ Spanish ○ Other: _____

Marital Status:
- ○ 5\Ø2\ŮŠŘ
- ○ Domestic Partner
- ○ Legally Seperated
- ○ Married
- ○ Single
- ○ Widow

Birth Sex:
- ○ Female
- ○ Male
- ○ Prefer not to answer

Current Gender:
- ○ Female
- ○ Male
- ○ Neither exclusively masculine nor feminine (Non-binary)

Gender Identity:
- ○ Female
- ○ Female-to-Male(FTM)/ Transgender Male
- ○ Male
- ○ Male-to-Female (MTF)/ Transgender Female
- ○ Prefer not to answer

Sexual Orientation:
- ○ Bi-sexual
- ○ Homosexual
- ○ Heterosexual
- ○ Prefer not to answer

Preferred Pronoun:
- ○ He/Him/His
- ○ She/Her/Hers/They
- ○ Them/Theirs
- ○ Other: _____
- ○ Prefer not to answer

Race:
- ○ White
- ○ African-American/Black
- ○ Native American or Alaska Native
- ○ Asian
- ○ Native Hawaiian/Pacific Islander
- ○ Other: _____

Ethnicity:
- ○ Latino/Hispanic
- ○ Non-Latino Hispanic

Homeless:
- ○ In Transition
- ○ Lives in the streets
- ○ Doubling up
- ○ Not Homeless

Are you a Veteran of the US Military:
- ○ Yes
- ○ No

I/patient's representative Decline ○ Consent ○ the right in submitting an application for the sliding scale fee discount

Family Size: How many people are in your family? _____ **Yearly Income**: _____ **Refuse to Provide (patient's Initials)**:_____

What type of Health Insurance do you have? Private Insurance: ☐ Medi-Cal: ☐ Medicare: ☐ No Insurance: ☐

How did you hear about us? Friends/family member: ☐ Television: ☐ Radio: ☐ Referral: ☐ Social Media: ☐ Bus: ☐ Mailer: ☐ On-line Ad: ☐

Experience with Agriculture/ Farm work: (planting, picking, preparing the soil, packing house, dairy, driving a truck for any type of farm work)

1. In the last two years, have you or anyone in your family, worked in any type of agriculture farm work? ○ Yes ○ No
2. In the past two years, have you or a member of your family moved to another area and lived away from home in order to work in any type of agricultural work? ○ Yes ○ No
3. Have you or a member of your family stopped migrating to work in agriculture (farm work) because of a disability or age? ○ Yes ○ No
4. Are you seeking employment in agriculture? ○ Yes ○ No

Office use:
Yes- #1, #4 "Seasonal"
Yes- #2, #3 "Migrant"

Whom may we contact in case of an emergency?
Name: _____ Relationship: _____ Telephone number: _____

Responsible Person (Parent or Legal Guardian signing this form):
First Name: _____ Last Name: _____DOB: _____
Mailing Address: _____ City: _____ State: ____ Zip Code: _____
Contact Telephone Number: _____ Relationship to Patient: _____

AUTHORIZATION AND CONSENT (Please Initial):

- ☐ I/patient's representative consent I am presenting at Omni Family Health for examination, diagnosis, and /or treatment of my health, medical, or dental condition.
- ☐ I understand I am financially responsible for all charges rendered for services to my dependents or me as my insurance carrier may pay less than the actual bill: this includes the remaining balance after payment of insurance benefits, deductible, and co-payments.
- ☐ I/patient's representative authorize the release of medical information to other entities in order to resolve the claim. (Refer to Notice of Privacy)

Signature of Patient/Guardian: _____ **Date**: _____

Office Use Only *After patient registration form is completed, Front Office Clerk shall enter information in patient's electronic health record and scan form into the correct patient chart.*

CONSENT FOR TREATMENT

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Patient name: _____ DOB: _____

Section A: Consent for Treatment

I hereby consent for the use or disclosure of my individually identifiable health information to carry out treatment, payment, or health care operations, this Includes assignment of benefits.

I consent to examinations, treatments, procedures, and blood tests ordered by my physician and other health care providers, including blood tests for communicable diseases such as hepatitis and HIV/AIDS.

This consent is authorized for the following health care provider(s):
Omni Family Health- Physicians, Nurse Practitioners, Physician Assistants, and medical staff.

- I understand I have the right to review the Notice of Privacy Policies and may request a copy at any time.
- I understand that state law requires the reporting of certain positive results such as hepatitis and the antibody for the AIDS virus to the health department.
- I have the right to revoke the consent in writing, except to the extent the provider has taken action prior to the revocation.
- I understand this authorization is voluntary.

Section B: Authorization to Share Protected Health Information

In order to disclose or discuss any personal health information to your family or designee, we must have a signed consent on file allowing Omni Family Health to share information about your care. Please list the names of those you would like to be involved in your health care. This form will be valid until you make changes or provide updates in writing. A verbal consent will not be honored.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize Omni Family Health to share information related to my health status to the individual(s) listed above.

I understand this may include information such as: diagnosis, prognosis, treatment plans, medications, test results, appointment reminders, medical billing, insurance, and any other medical Information relevant to my care.

___ I decline to have my medical information shared with family or a designee.

Patient signature: _____ Date: _____

STATEMENT OF FINANCIAL RESPONSIBILITY

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Omni Family Health

WELCOME!
Thank you for choosing Omni Family Health (OFH) as your primary care provider. We are committed to providing you with the best possible care. Your clear understanding of our practices' financial policy is important to our professional relationship. We make every effort to keep our fees reasonable while at the same time covering the cost of services we provide. Payment of your bill is considered part of your overall treatment and responsibility. In order to keep healthcare costs to an absolute minimum, we have adopted the following policies.

Fees and Payments
Fees are standard and based on the complexity of your visit. Payment in full is required at the time of your visit and can be made with cash, personal check, money order, and all major credit cards.

While filing insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date services are rendered. OFH will file claims to insurances provided (primary & secondary) during registration. Your insurance is a contract between you and your insurance company and we are not party to that contract. In order for us to file a claim on your behalf, you must present a **CURRENT** copy of your insurance card(s) at each visit and communicate any changes to your personal information.

Not all services are a covered benefit in all policies, so it is very important that you understand the provisions of your individual policy. Insurance companies select certain services that they will not cover, therefore we can't guarantee payment of all claims by your insurance company. Some common examples of non-covered services are labs, radiology, pharmacy, dental supplies and/or labs, contact lenses, mental health, and chiropractic, etc. Rejection of your claim does not relieve you of your financial responsibility to OFH.

PLEASE NOTE: Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses are made based on medical information, not based on coverage by insurance companies. To request a diagnosis to be changed solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and is considered insurance fraud.

Required at Check-in:

1. Verify personal contact information
2. Present a current copy of the insurance card
3. Present current picture ID
4. Payment of any outstanding balance
5. Payment for today's visit

We will verify your coverage up to three days prior to your visit. If we are unable verify insurance eligibility, you will be considered self-pay and will be responsible for payment in full at your visit.

Sliding Fee Discount Scale
As a Federally Qualified Health Center (FQHC), it is OFH's policy to make healthcare affordable by offering a sliding fee discount (SFD) program to patients who qualify based on their family size and income level in accordance with the Federal Poverty Guidelines (FPG). Services not covered under the Sliding Fee Discount Scale will be your responsibility to make payment in full at the time of service. These services are labs, radiology, pharmacy, dental supplies and/or labs, and contact lenses.

Self-Pay
In order to address the needs of our patients without insurance and patients with coverage limitations that do not qualify for our sliding fee discount, we accept self-pay patients at our usual and customary fees. Payment for medical services provided is due at the time of service.

Co-Payments
Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. If you do not have your co-payment, your appointment may be rescheduled.

Delinquent Balance Appointment
Non-sliding fee discount patients with a delinquent balance are required to make payment in full for all services. A delinquent account is defined as a patient balance in excess of 120 days if the patient has not made any payments or sought assistance via financial hardship during this time. If such payment is not made, the balance may be referred to an outside collection agency.

Medicare
We gladly accept Medicare and accept payment at the Medicare allowed amount. Patients are responsible for deductible and / or 20% co-insurance. Medicare or secondary carriers do not cover some services, you may receive an Advance Beneficiary Notice (ABN) to understand what services might not be covered before proceeding, please be certain that you understand which aspect of your service is covered before proceeding. We will submit a claim to any supplemental plan you have, as long as you provide all the necessary policy information.

Annual Eye Exams
Please verify with your insurance that you are eligible for vision exams and eyewear materials before making your appointment. Some insurances may not cover all vision services, including, but not limited to, eye exams and/or eyewear materials.

Family Medical Leave Act and Disability Paperwork
If your employer requires Family Medical Leave Act (FMLA) or Disability paperwork to be completed by your provider, we offer the following options:

I. A form created by our practice that meets the needs of both the employer and patient. Patients may request this form be filled out at any time to clarify their current condition. The turnaround time for this form can be up to 15 (fifteen) business days and there is no charge to the patient for this service.

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Medical Records
All OFH patients may request a copy of their medical records at no charge to the patient.

MISCELLANEOUS CHARGES

Returned Check Charge
Non-sufficient funds (NSF) checks are subject to a $25.00 fee (this is not included in any fees incurred by your financial institution)

Collection Charge
Accounts that are not paid within 120 days from the date of service may be sent to an external collection agency and reported to one or all national credit bureaus. In addition to your outstanding balance, a 33% surcharge may be added.

Refunds
Patient refunds are processed on the third Thursday of every month. Any accounts that have outstanding claims will not be eligible for a refund. Cases involving implantable items will be assessed on an individual basis.

Responsible party initial the following,

I. _____ Estimated fees for all services, including unpaid balances, deductibles, co-payments, and non-covered services are due at the time of service.

II. _____Returned check fee charges are $25, and will be incurred for each returned check.

III. _____ We have made prior arrangements with many insurance carriers to accept an assignment of benefits. This means we will bill contracted insurance plans and will hold you responsible for the portion the carrier assigns as your responsibility (deductibles, coinsurance, co-pay, and/or non-covered services).

IV. _____We accept dental, behavioral health, vision and medical plans. The type of service you receive will dictate which type of insurance we bill.

V. _____ Portions collected for dental procedures are estimates only. Once your insurance carrier has addressed the claim(s), you will receive a statement for any remaining balance deemed your responsibility. Payment will be due upon receipt of statement. If your insurance carrier pays you directly for services billed by OFH, it is your obligation to promptly forward the payment to us.

VI. _____ A credit card on file may be used to secure any outstanding balances owed to OFH after your insurance plan has paid their portion. This may also be used for deductibles, co-payments, and arrangements established between you and our Finance Department. This process allows OFH to resolve open balances in a timely manner.

VII. _____ We will not become involved in disputes between you and your insurance carrier regarding deductibles, co-payments, non-covered charges, etc. We will, however, make certain advanced authorization requests to alleviate as many non-covered fees as possible. Your insurance policy, however, is a contract between you and your carrier. Contact your insurance representative and understand your coverage and benefits prior to undergoing any service/procedure.

At OFH, we understand financial problems may affect timely payment. We encourage you to communicate any such problems to our Finance Department, so that we may assist you in keeping your account in good standing. We may provide you with additional resources such as payment arrangements, sliding fee discount applications, or state Medi-Cal contact information. Adjustments will only be made based upon contractual obligations with insurance or with prior written approval. Should you have any questions, please contact our Billing office at 661-758-7740.

ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL OR ELECTRONIC SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HERIN AND AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

Printed Name of Patient: _____ Date of Birth: _____

_____ Date: _____
Patient/Responsible Party/Guardian Signature

PATIENT RIGHTS AND RESPONSIBILITIES

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Omni Family Health

At Omni Family Health (OFH), patients have the right to be free of discrimination when receiving care and to be treated respectfully by providers and staff. OFH complies with applicable civil rights policies, state, and federal laws.

Patients Have the Right...

1. To be treated kindly and with respect for your personal values, beliefs, and preferences to be honored.
2. To request an interpreter if needed, at no cost to you
3. To know the names of the licensed health care providers and other health care workers who are taking care of you.
4. To know about your health condition, diagnosis, be involved in making decisions about your medical care, and to understand the chances of getting better.
5. To keep your medical records and discussions about your care private.
6. To be cared for in a safe place where no one hurts you mentally, physically, sexually, or verbally. No one should abuse, neglect, exploit, or harass you.
7. Obtain care from other clinicians within the Primary Care Medical Home (PCMH):
    a. Seek a second opinion
    b. Seek specialty care
8. Select the primary care provider of your choice.

Family Planning Patients have the right...

1. To decide whether or not to have children and when.
2. To know the effectiveness, possible side-effects, and problems of all method of birth control.
3. To be involved in choosing the right birth control method.

Children and Adolescents Rights...

1. The family/guardian of a child or adolescent patient has the right and responsibility to be involved in decisions about the care of the child. A child or adolescent has the right to have his or her wishes considered in the decision-making as limited by law.
2. A child or adolescent patient has the right to expect that care and physical environment will be appropriate to his or her age and needs.

Patients are Responsible...

1. To be polite to OFH staff, other patients, and follow OFH rules. Share concerns calmly and do not threaten or abuse anyone.
2. To follow your provider's advice, take your medicines as directed, and keep your appointments. If you feel different or something changed in your health, tell someone on your care team right away.
3. To make sure to pay for your medical services, like copays or any part of the bill that your insurance does not cover. Share your insurance details with us so we can take care of your billing correctly and make sure you get the right care.
4. To ask questions, share concerns, and help decide your treatment plan.
5. To Be Honest to tell doctors and nurses the truth about your health, how you are feeling, and medicines you are taking.