WAKE HEALTH SERVICES
A Community Health Center

******** FOR OFFICE STAFF ONLY ********
☐RQ ☐NBRP ☐FCHS
☐AFM ☐NBRD ☐SWOC
☐SWFM
MRN _____SFS Patient Type____

REGISTRATION

Please complete to the best of your knowledge. For areas that do not apply to the patient please enter "N/A".

Patient's Name *First* *MI* *Last*				Date of Birth (DOB) *MM/DD/YY* ☐ Under 18?	
Mailing Address *Street*		*City*	*State*	*Zip*	*County*
Physical Address *Street* ☐Same as Mailing		*City*	*State*	*Zip*	*County*
Public Housing Projects ☐ Yes ☐ No Social Security # / Tax ID	Race (check all that apply) ☐ Asian ☐ White ☐ American Indian/Alaska Native ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Refuse to provide	Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Refuse to provide Sex ☐ Female ☐ Male	Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Veteran? ☐ Yes ☐ No	Preferred Language: Are interpreter services needed? ☐ Yes ☐ No	
Does the patient have Medical Insurance? ☐ Yes ☐ No if no, please skip to Part II.	Primary Insurance Carrier		Secondary Insurance Carrier		

Part II - CONTACT INFORMATION

1st Phone ____ - _____ - _____ ☐ Cell ☐ Home ☐ Work	2nd Phone ____ - _____ - _____ ☐ Cell ☐ Home ☐ Work	Email	
Emergency Contact: *Name*	*Relationship*	*Phone*	
How did you hear about us? ☐ Family/ Friend ☐ Shelter ☐ Health Dept. ☐ Hospital ☐ Media ☐ Social Services ☐ Other _____			
Guarantor's Name *First* *MI* *Last* ☐Same as Patient (Parent or guardian if applicable)		DOB *MM/DD/YY*	
Guarantor's Address *Street* *City, State, Zip*			
Social Security # / Tax ID	Relationship	Phone ____ - _____ - _____ ☐ Cell ☐ Home ☐ Work	
Child or Minor lives with:	Employer	Work Phone ____ - _____ - _____ ☐ Cell ☐ Home ☐ Work	

Please circle the range below indicating your estimated annual household income according to the number of people living in your home. Wake Health Services, Inc. is required to report this information to the Federal government, and it helps us to better understand the needs of the communities we serve. *No identifying information shall be disclosed in any of our required reports. Your anonymity is protected.*

# of People in Household	EXAMPLE: *$0 - $11,670*			
1	*$0 – $11,670*	*$11,671 - $17,505*	*$17,506 – $23,340*	*More than $23,341*
2	*$0 – $15,730*	*$15,731 - $23,595*	*$23,596 – $31,460*	*More than $31,461*
3	*$0 – $19,790*	*$19,791 - $29,685*	*$29,686 - $39,580*	*More than $39,581*
4	*$0 – $23,850*	*$23,851 - $35,775*	*$35,776 - $47,700*	*More than $47,701*
5	*$0 – $27,910*	*$27,911 - $41,865*	*$41,866 - $55,820*	*More than $55,821*
6	*$0 – $31,970*	*$31,971 - $47,955*	*$47,956 - $63,940*	*More than $63,941*

Release and Authorization/ Signature on File Statement

I hereby request, authorize and consent to medical care, including diagnostic procedures, HIV testing, and medical treatments as appropriate related to the health problem(s) for which I have sought services from Wake Health Services, Inc. (Wake Health). I authorize Wake Health to release information about me to my insurance company/companies, Medicare or Medicaid as appropriate. I request payment of medical insurance benefits related to these visits be paid directly to Wake Health. I understand that I am responsible for payment in full for any of my bills or services not paid by insurance.

_____ _____ ____/___/_____
Patient/Guarantor/Guardian Print Patient/Guarantor/Guardian Signature Date

WAKE HEALTH SERVICES
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Financial Policies

We are committed to providing you the best possible care. Your clear understanding of our financial policies is important to our professional relationship. PLEASE ASK if you have any questions about our fees, our policies and procedures, or you need us to explain your responsibilities.

We look forward to a long and healthy relationship with you!

Insurance information

Wake Health Services accepts Medicare, Medicaid, NC HealthChoice and most major insurers. It is your responsibility to know your insurance plan and to verify coverage for referrals to other doctors, recommended tests, and laboratories. We make every effort to refer you to providers, labs, and x-ray facilities that are members of most plans, but it is not possible for us to know the details of every plan. **If you are in doubt about what is covered, please call your plan's member services department and check. This office cannot be responsible for out-of-pocket expenses incurred from utilizing the wrong provider or facility, or for undergoing non-covered tests or procedures.**

You are responsible for the co-payment required by your insurance company. We will collect a co-pay from you at the time of your visit prior to receiving services, and then file an insurance claim for you with your carrier. We will bill you for any balances assigned to you by your carrier, including any coinsurance, deductible, and denied charges. You are expected to pay your balance within 30 days.

You are responsible for providing up-to-date insurance policy information and changes in your address and phone number each time you visit us.

Lab Tests and other charges:

Wake Health uses LabCorp for our lab tests, as well as other sources for x-rays, biopsies, PAP smears and cultures. **You will receive separate billing from LabCorp and other companies who perform the processing and evaluation of those tests.** Financial questions should be directed to the telephone number on the lab bill.

For the UNINSURED & MEDICARE patients:

If you do not have insurance or have Medicare, we offer a discount on fees based on family size and income, for residents of Wake and Franklin Counties only. To receive services, you must apply for our Discount Fee Program. Please tell the front desk staff and they will assist you with applying for this program.

Payment Requirements:

Payment (or co-payment) is due at the time of services. We accept in-state checks, money orders, Visa, MasterCard and Discover Card.

If your balance exceeds $200, and you have made no effort to make payments or establish a payment plan for 6 months, we may terminate medical and dental services to you.

If you write a bad check (checks written on insufficient funds), you will be asked to make payment in full within 30 days, including a $25 return check fee. At that time, as well as for all future visits, you must pay in cash or with a debit card or credit card.

Missed Appointments

You are required to give us 24 hours' notice if you have to miss, or be late for, your appointment. This allows us to care for another waiting patient.

If you cancel your appointment with less than a twenty-four hour notice, or do not show up for your appointments three times within a six month period, you will be moved to a "Do Not Schedule in Advance Status."

Once you are moved to the Do Not Schedule in Advance Status, you will be able to be seen at all Wake Health sites as a walk-in patient only. You will not be able to schedule an appointment in advance for a six month period.

After the six month period is up, you may schedule appointments in advance again. If you are moved to Do Not Schedule in Advance Status twice, you will be considered for termination as a patient of Wake Health with a review of their record by the Practice Administrator and their personal Primary Care Physician.

I have read, and I agree to, the Financial Policies of Wake Health Services.
I understand I am responsible for making payments for my medical care according to these policies.

Name of responsible party (print)

_____

Name of child (print)

_____

Responsible party's signature_____

(Date)_____

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HIPPA AUTHORIZATION / ACKNOWLEDEMENT

PLEASE READ THIS ENTIRE PAGE AND RESPOND AS DESIRED

I acknowledge receiving ***Wake Health Services, Inc.***'s Notice of Privacy Practices. I understand that ***Wake Health Services, Inc.*** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that ***Wake Health Services, Inc.*** will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in ***Wake Health Services, Inc*** 's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____ _____ _____
Patient/Guardian Name Patient/Guardian Signature Date

****

I authorize Wake Health's staff and providers to leave messages at my home telephone number ❑ YES ❑ NO

I authorize Wake Health's staff and providers to leave messages at my work telephone number ❑ YES ❑ NO

****

I authorize Wake Health's staff and providers to send mail to my home address ❑ YES ❑ NO

I would prefer to receive mail from Wake Health's staff and providers at the following address: _____

_____

****

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____ _____
Patient Signature Date

****

I also authorize ***Wake Health Services, Inc.*** to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

_____ _____
Patient Signature Date

_____ _____ _____
Witness Name Witness Signature Date

Updated 04/2009

Rev 7/12

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******** FOR OFFICE STAFF ONLY ********
☐RQ ☐NBRP ☐FCHS
☐AFM ☐NBRD ☐SWOC
☐SWFM
MRN _____SFS Patient Type____

SLIDING FEE SCALE (SFS) ELIGIBILITY QUESTIONAIRE

1- **Are you claimed as a dependent on a relative's taxes?** ☐ Yes ☐ No

2- **Have you applied for Medicaid or had Medicaid coverage in the past year?** ☐ Yes ☐ No

Adults WITHOUT Children under 19 -Answer Below

3- **Are you a US Citizen, refugee or lawful permanent resident admitted at least five years ago?**
[ ] Yes- Go to question 4 [ ] No- Go to Part III

4- **Are you age 65 or older?**
[ ] Yes- Encourage to apply for Medicare [ ] No- Go to question 5

5- **Are you receiving Social Security Disability? Have you been or will you be disabled for 12 months? Are you legally blind?**
[ ] Yes-Encourage to apply for Medicaid [ ] No- Go to Part III

Adults WITH Children under 19 - Answer Below

3- **Are you under age 21, pregnant, OR the primary caretaker of a child living your home is under the age of 19?**
[ ] Yes- Go to question 4 [ ] No- Go to Part III

4- **Are you a US citizen, refugee, or lawful permanent resident admitted at least 5 years ago?**
[ ] Yes- Encourage to apply for NC Medicaid* [ ] No- Go to Part III
*Only if patient is not in a pending status or has recently applied to NC Medicaid

SLIDING FEE APPLICATION

Please complete the form, answer ALL questions and submit ALL applicable documents from the check list below. When complete, please sign the bottom of the page. Incomplete applications (including lack of documents) will not be processed.

Required Supporting Documents for Sliding Fee Scale Application (Please Check All That Apply)	
☐ Photo I.D for patient and ALL adults claimed as dependents ☐ Proof of Homeless Status (If Homeless ONLY) ☐ Birth certificate, social security card, insurance card, or School I.D. for all dependents under 18 ☐ Pay check stubs showing GROSS amount for past 30 days for patient and all working claimed dependents, or letter from employer ☐ If self-employed, must obtain Schedule C and Profit & Loss Statement from current tax return	☐ Proof of Unemployment For letter, call Employment Securities Commission 1-888-737-0259. ☐ Social Security Income - early retirement, retirement, or disability. For letter, call Social Security Admin 1-800-772-1213. ☐ Proof of pension ☐ Proof of alimony ☐ Proof of county residence (Wake and Franklin Counties only) ☐ Attestation Documentation, if applicable

HOUSEHOLD
Please list family members who live in your household and are claimed as dependents for tax purposes: **Total Household Size: _____**

Name	DOB	SSN/TIN
Name	DOB	SSN/TIN
Name	DOB	SSN/TIN
Name	DOB	SSN/TIN
Name	DOB	SSN/TIN
Name	DOB	SSN/TIN

If you will be separately applying for the Drug Assistance Program (DAP) you will be asked to provide your most recent tax forms to the pharmaceutical companies to qualify for the program.

I HEREBY CERTIFY THAT I LIVE IN THE STATE OF NORTH CAROLINA, AND THE INFORMATION SUBMITTED IS TRUE TO THE BEST OF MY KNOWLEDGE. I also give permission to Wake Health Services, Inc to contact any individual that may have information regarding my eligibility. I declare, under penalty of perjury, that the information on this form, my Federal Income Tax Return, and my accompanying schedules submitted with this application to Wake Health Services are true, correct and complete. If it is determined that any of the information provided is not accurate or I fail to immediately notify Wake Health Service of any changes, I understand that I will be removed from the SFS program and all charges will be reinstated. I also agree to pay the determined co-pay at the time of my medical or dental visits. I understand that failure to pay the co-pay at the time of service may result in my removal from the SFS program.

_____ _____ ____/____/_____
Patient/Guarantor/Guardian Print Patient/Guarantor/Guardian Signature Date

SFS Supporting Documentation (for staff use only)

I. FOLLOW UP QUESTIONS

1. Is patient married, divorced, or widowed?
- a. Married: spouse must be listed on application and documentation of his/her income is required, if applicable
- b. Proof of alimony required
- c. Widowed: Proof of widow's pension is required, if applicable

2. Is the person applying for the discount program a full time student AND claimed as a dependent on their parent's taxes?
- a. If yes, ask: do parents provide insurance for them? ☐ Yes ☐ No
- b. If yes, they are not eligible for the SFS.
- c. If no, the patient's parent's MUST be included on the SFS application & all income documentation is required.

3. Has the patient applied for Medicaid?
If no, complete Part III

4. Is the patient a veteran?
- a. If yes, encourage them to apply for VA benefits but they can apply for our SFS.

5. Does patient and/or spouse have zero income?
- a. If yes, need documentation from county regarding patient resources **OR**
- b. Identification and proof of income for all members of household **OR**
- c. WHSI's Zero Income Attestation completed by a member of the household where the patient is staying **OR**
- d. Shelter or Agency documentation on letterhead (if zero income and homeless)

6. Does patient have child/children?

I. If yes, do the child/children have insurance? ☐ Yes ☐ No
- a. If yes and the insurance is Medicaid, has the parent(s) applied for Medicaid also?
- b. If no, encourage the parent to apply for Medicaid

II. Do children receive SSI, disability, or any other income? ☐ Yes ☐ No
If yes, documentation is required and that is used as part of the household income

II. INCOME WORKSHEET

Sources of Income for all Members Living in Household Claimed as a Dependent:

Check Stubs (30 days)	$_____wk/bi-wkly/mo	_____yr	Social Security Income	$_____mo	_____yr
Letter from Employer	$_____ wk/bi-wkly/mo	_____yr	Pension	$_____mo	_____yr
Current Tax Returns	$_____yr				
Unemployment Letter	$_____wk	_____yr	Proof of Alimony i.e. written agreement, court award etc.	$_____mo	_____yr
Workmen's Compensation	$_____mo	_____yr	Dividends/Interest	$_____mo	_____yr
Disability Benefits	$_____mo	_____yr	Other Income (e.g. one-time pmt)	$_____mo	_____yr
Income from Property	$_____mo	_____yr			

Total Annual Household Income:_____

Required Supporting Documents for Sliding Fee Scale Application

- ☐ Photo I.D for patient and ALL adults claimed as dependents
- ☐ Proof of Homeless Status (If Homeless ONLY)
- ☐ Pay check stubs showing GROSS amount for past 30 days for patient and all working claimed dependents, or letter from employer
- ☐ Birth certificate, social security card, insurance card, or School I.D. for all dependents claimed under 18
- ☐ Current tax returns if (1) self-employed (2) claiming an adult as a dependent (3) applying for drug assistance or (4) living off of dividends, stocks, savings, etc.
- ☐ Proof of Unemployment
  For letter, call Employment Securities Commission 1-888-737-0259
- ☐ Social Security Income - early retirement, retirement, or disability
  For letter, call Social Security Admin 1-800-772-1213
- ☐ Proof of pension
- ☐ Proof of alimony
- ☐ Proof of county residence
- ☐ Attestation Documentation, if applicable

_____ _____ _____/____/_____
Staff Member Completing Application Print | Staff Member Completing Application Signature | Date

_____ _____ _____/____/_____
Manager/Manager Designee Print | Manager/Manager Designee Signature | Date

III. INCOME CALCULATIONS

Income Payments	Check Amounts	Example	Sample Calculation	Annual Income
Monthly		$700 on 1st, (e.g. disability check)	Multiply by 12	$700 x 12 = $8,400 annual
Bi-Monthly	**Same**	$350 on 15th, $350 on 30th	Multiply by 24	$350 x 24 = $8,400 annual
Bi-Monthly	**Different**	$200 on 15th, $150 on 30th	Add together, multiply by 12	$350 x 12 = $4,200 annual
Weekly	**Same**	$100 x 4 weeks	Multiply by 52	$100 x 52 = $5,200 annual
Weekly	**Different**	$100, $50, $150, $100	1) Add all 4 amounts 2) Divide by 4 for average 3) Multiply by 52	$100 + $50 + $150 + $100 = $400 $400 / 4 = $100 per week $100 x 52 = $5,200 annual
Bi-Weekly	**Same**	$200 every 2 weeks	Multiply by 26	$200 x 26 = $5,200 annual
Bi-Weekly	**Different**	$100, $300	1) Add both amounts 2) Divide by 2 for average 3) Multiply by 26	$100+$300 = $400 $400 / 2 = $200 per bi-week $200 x 26 = $5,200 annual

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AUTHORIZATION TO CONSENT TO HEALTH CARE FOR MINOR

I, _____, of _____ County, _____State, am the custodial parent/guardian having legal custody of _____.
(Name of Minor)

In my absence the following person(s)* to do any acts which may be necessary or proper to provide for the health care of the minor child, including, but not limited to, the power (i) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (ii) to consent to and authorize any health care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures.

Names of Authorized Persons:

_____ _____

_____ _____

This consent shall be effective from the date of my signature below until _____.

By signing here, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document and understand the full import of this grant of powers to the agent named herein.

Parent/Guardian Name: _____(Print)

Parent/Guardian Signature _____ Date: _____

Witness Name: _____(Print)

Witness Signature: _____ Date: _____

***Persons to whom authority to consent to treatment of minors is delegated must be 18 years of age or older or an emancipated minor. The witness may not be the person designated by the parent to consent to healthcare for the minor.**

Implemented 12/03, Revised 6/1/05