Katy Trail Community Health

PATIENT REGISTRATION FORM

(Please Print)

PATIENT INFORMATION					
Patient's First Name:	Middle Initial:	Last Name:	Gender at Birth: ❑ Male ❑ Female	Social Security Number:	Birth Date: / /
Street Address:		City:	State:		Zip Code:
Mailing Address: ❑ Same as above			Home Phone Number where messages can be left: ( )		
Email Address:			Cell Phone Number where messages can be left: ( )		
Preferred Pharmacy:			Preferred Pharmacy City & Street:		
Does the patient have any problems with: ❑Vision ❑Hearing ❑Reading ❑Speaking Explain:					

PARENT/LEGAL GUARDIAN/SPOUSE INFORMATION		
Name:	Phone Number:	Relationship Type: ❑ Mother ❑ Father ❑ Spouse ❑ Guardian (Specify): _____
Name:	Phone Number:	Relationship Type: ❑ Mother ❑ Father ❑ Spouse ❑ Guardian (Specify): _____

PERSON(S) WHO MAY BE NOTIFIED IN CASES OF EMERGENCY OTHER THAN PARENT/LEGAL GUARDIAN		
Name:	Phone Number:	Relationship to Patient :
Name:	Phone Number:	Relationship to Patient :

MEDICAL INSURANCE INFORMATION

Please present ALL insurance cards to the front desk

Mark Insurance Type below:

Medical Insurance: ❑ Medicare ❑Medicaid ❑ BCBS/Anthem ❑Tricare ❑ Other Commercial: _____

Subscriber Name (if different than the patient): _____ Relationship to Patient: ❑ Spouse ❑ Parent ❑ Step Parent

Subscriber's Birthdate: _____ Subscriber's Social Security Number: _____

Subscriber's Phone Number: _____ Subscriber's address: _____

Dental Insurance: ❑ Medicare ❑Medicaid ❑ BCBS/Anthem ❑Tricare ❑ Other Commercial: _____

Subscriber Name (if different than the patient): _____ Relationship to Patient: ❑ Spouse ❑ Parent ❑ Step Parent

Subscriber's Birthdate: _____ Subscriber's Social Security Number: _____

Subscriber's Phone Number: _____ Subscriber's address: _____

By participating in certain federal programs we are required to request the following information

Race

Please check all that apply

- ❑ American Indian/Alaskan Native
- ❑ Asian
- ❑ Black/African American
- ❑ Native Hawaiian
- ❑ Other Pacific Islander
- ❑ White

Ethnicity

- ❑ Latino or Hispanic
- ❑ Not Hispanic

Primary Language:

- ❑ English
- ❑ Spanish
- ❑ Russian
- ❑ Ukrainian
- ❑ Other: _____

Marital Status

- ❑ Divorced
- ❑ Married
- ❑ Single
- ❑ Separated
- ❑ Widowed

Highest Level of Education:

- ❑ 1-Not yet in school
- ❑ 2-Pre-School/Kindergarten
- ❑ 3-Grade School
- ❑ 4-Middle School
- ❑ 5-High School (Currently)
- ❑ 6-High School Grad/GED
- ❑ 7-Did Not Complete High School
- ❑ 8-Technical/Trade School
- ❑ 9-Some College
- ❑ 99-College Graduate

Are you a current student?

- ❑ Full Time ❑ Part Time
- ❑ Not Current Student

Employment Status:

- ❑ Full Time ❑ Part Time
- ❑ N/A

Public Housing:

Do you currently live in public (income-based) housing?:

❑ YES ❑ NO

Veteran Status

- ❑ Not a Veteran
- ❑ Veteran

Gender Identity

- ❑ Male
- ❑ Female
- ❑ Transgender Male
- ❑ Transgender Female
- ❑ Gender Neutral
- ❑ Decline to specify

Sex by Orientation:

- ❑ Straight or heterosexual
- ❑ Lesbian, gay or homosexual
- ❑ Bisexual
- ❑ Something else
- ❑ Don't know
- ❑ Decline to answer

Patient Self Determination Act:

Please check all that apply

- ❑ None
- ❑ DNR
- ❑ Living Will
- ❑ Durable Power of Attorney
- ❑ HC Proxy

HOMELESS STATUS

Please check the statement which best describes your housing situation:

- ❑ I live in my home which I rent, lease, or own.
- ❑ I am staying with friend(s) or family member(s) temporarily
- ❑ I am staying in transitional housing (such as recovery home or recently released from jail or hospital without stable housing to return to)
- ❑ I live in a public or private facility with temporary shelter (shelter or motel)
- ❑ I live on the streets, in a car, park, sidewalk, abandoned building, etc

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INCOME STATUS

Number of Persons in Household: _____

Estimated Annual Household Income:❑ $10,000 or below ❑ $10,001-$20,000 ❑ $20,001-$30,000 ❑ $30,001-$40,000 ❑ $40,001-$50,000 ❑ $50,001-$60,000 ❑ $60,001-$70,000 ❑ $70,001-$80,000 ❑ $80,001-$90,000 ❑ $90,001-$100,000

PROTECTED HEALTH INFORMATION Person(s) who may obtain my medical and/or dental health information. This may include verbal and/or copies of records unless specified by you. Note: This does not include psychiatry or behavioral health records		
Name:	Phone Number:	Relationship type:
Name:	Phone Number:	Relationship type:

PATIENTS UNDER 18 years old ONLY: PERSON(S) WHO MAY ACCOMPANY MINOR & MAKE MEDICAL/DENTAL/MENTAL TREATMENT OTHER THAN PARENT/LEGAL GUARDIAN		
Name:	Phone Number:	Relationship type:
Name:	Phone Number:	Relationship type:

Consent to Treat
By signing below I am giving consent for myself/my ward to receive any treatment as deemed necessary by the attending health care provider. KTCH provides services without out regard to religion, race, color, national origin, handicapping condition, age, sex, number of pregnancies, or marital status. By signing below I also consent to treatment for myself/my ward by KTCH dental providers and/or students from UMKC school of dentistry and SFCC when or if dental services are provided. Additionally, title X services are provided solely on a voluntary basis and acceptance of a family planning service is not a prerequisite to eligibility or receipt of any other service.

Initial: _____

Consent & Agreement for Patient Portal:
We are committed to protecting your personal health information in compliance with the law. By signing below you are acknowledging that you have read, fully understand, agree and aware of the risks and benefits associated with online communication via patient portal between KTCH and yourself. You agree to adhere to the policies set forth by KTCH as well as any other instructions or guidelines that may be imposed for online communications.

Initial: _____

Receipt of Privacy Statement:
We are committed to protecting your personal health information in compliance with the law. By signing below you are acknowledging that you have read and agree with the KTCH privacy statement and understand that at any time upon request, you may obtain a copy of the KTCH Statement of Privacy Practices

Initial: _____

By signing below I am acknowledging that I have completed the information in this packet to the best of my knowledge. By signing below and initialing on the above lines, I am acknowledging that I have read and understand the above information.

SIGNATURE: _____ **DATE:** _____

Witness Signature: _____ **DATE:** _____

Patient Rights

At Katy Trail Community Health, we are committed to providing you a **patient center medical home (PCMH)**. A patient centered medical home is not a place of residence and does not change where you live. Instead a medical home is where you get healthcare and see your primary care provider (PCP). A PCP can be a doctor, nurse practitioner or a dentist. Your PCP leads a team of individuals within the organization who, as a care team, will take responsibility for the ongoing care of each patient. You and your family are an essential part of the care team. As a patient, you have certain rights. Understanding those rights will help you to get the best possible care. You have the right to:

- ☑ Receive compassionate and respectful care regardless of age, sex, race, national origin, religion, disability, or communicable disease.

- ☑ Personal Provider – each patient has an ongoing relationship with a primary care provider (PCP) who will give complete and continuous care.

- ☑ Comprehensive Medical Care – the PCMH is responsible for meeting the majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. You have the right to be well informed about your diagnosis, treatment, and chances for recovery in words you can understand. This information should include the specific treatment, medical risks, benefits, side effects.

- ☑ Comprehensive Dental Care - the PCMH is responsible for meeting the majority of each patient's oral health care needs, including prevention and wellness and acute care. You have the right to be well informed about your diagnosis, treatment, and chances for recovery in words you can understand. This information should include the specific treatment, medical risks, benefits, side effects.

- ☑ Provider Directed Medical Practice – the PCP leads a team of individuals within the organization who, as care team, will take responsibility for the ongoing care of each patient. **Your care team includes your medical PCP, medical assistant, LPN, behavioral health consultant, care coordinator, and a case manager.** The care team will support the patient for self-management of their health and health care goals.

- ☑ Provider Directed Dental Practice - the PCP leads a team of individuals within the organization who, as care team, will take responsibility for the ongoing care of each patient. **Your care team includes your dental PCP, hygienist, dental assistant, expanded functions dental assistant, behavioral health consultant, and care coordinator.** The care team will support the patient for self-management of their oral health and oral health care goals.

- ☑ Whole Person Orientation – the PCP is responsible for providing for the entire patient's healthcare needs and takes responsibility for appropriately arranging care with other qualified professionals as needed.

- ☑ Behavioral Health Needs- The PCMH employs or contracts for BH Consultants and Psychiatrists. Your PCP may refer you to behavioral health for either chronic disease management or mental health services.

- ☑ Care is Coordinated – the PCMH coordinates care across all areas of the health care system, including specialty care, hospitals, home health care, and community services and supports. Such coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital.

- ☑ Accessible Services – a PCMH delivers services that are easy to get and with shorter waiting times for urgent needs, better in-person hours, and around-the-clock telephone access to a member of the care team. **The after-hours phone number is 660-851-9012**

- ☑ Quality and Safety – PCMH's are dedicated to improving quality of care by using evidence-based medicine and clinical decision-making tools to help providers, patients and families make decisions. Patients will always have the right to refuse recommended treatment to the extent permitted by law, and to be told what will happen to you medically if that is your choice. Express verbally or by letter, any complaints or recommendations concerning our services. You may communicate a complaint or grievance in writing at our main site at 821 Westwood, Sedalia, MO 65301, or by calling our main site at 660-826-4774.

- ☑ Privacy – You have the right to the privacy and confidentiality of all your records pertaining to your treatment, except as required by law or third party payment. Your medical and dental record can be read only by individuals directly involved in or supervising your treatment, monitoring the quality of your treatment, or authorized by law or regulation. You have the right to access the information contained in your medical record, within the limit of the law and facility policy. Please refer to the KTCH Notice of Privacy for additional information on your privacy rights.

Patient Responsibilities

The care you receive is partially dependent upon your acting in a cooperative manner with your health care providers, including communicating openly and honestly, following treatment plans, and respecting the facility standards of conduct. As a patient at Katy Trail Community Health, you are responsible for:

1. Following all facility rules as posted inside and/or outside the clinical facility. Respecting and considering other people, employees, the property of others, and property of Katy Trail Community Health.
2. Advising us of any changes in the following:
   Name, Address, Phone Number(s), Insurance Information, Income, and Family Size
3. Providing accurate and complete information about current symptoms, medical history, hospitalizations, medications, care obtained outside the practice, self care information, advance directives, and any other matters related to care.
4. Following instructions that you and your care team have agreed upon. Follow through on goals for self-management of your health.
5. Asking questions about your care that you may not understand or have questions about, including risks of procedures, outcomes, and costs of treatment.
6. Knowing what medications or drugs you are taking, why you are taking them, and the proper way to take them according to your PCP's instructions.
7. Keeping scheduled appointments, arriving on time for scheduled appointments, and for calling at least 4 hours in advance to cancel when you cannot keep a scheduled appointment. KTCH reserves the right to terminate service to patients who do not show for appointments more than three times in a 12 month period.
   a. **MEDICAL**: New patients are required to arrive 30 minutes in advance of their appointment. Please notify us at least 4 hours in advance of appointment cancellations. After missing four medical/behavioral health appointments within a calendar year the patient will be required to make all future appointments through the triage nurse. Patients may be removed from the list after writing a letter stating what steps they will take to ensure future appointments are not missed.
   b. **DENTAL:** New patients are required to arrive 30 minutes in advance of their appointment. If you are more than **10 minutes late for your dental appointment**, your appointment will be rescheduled. Please notify us at least 24 hours in advance of appointment cancellations. After missing two dental appointments the patient will be required to meet one of the following criteria, Wait six (6) months to schedule an appointment, write the provider a letter asking for the privilege to be seen again, meet with a care coordinator to discuss barriers to care.
8. Attending and supervising your children while in the facility.
9. Calling your pharmacy to request a refill 1 week before you run out of your prescription. If authorized by a KTCH provider, your request will be filled within 72 business hours.
10. Paying bills and fees promptly as defined in the financial policies.

I have read and understand the Katy Trail Community Health **Patient Rights and Responsibilities** and have been given an opportunity to obtain a copy for my personal records.

_____ _____

Signature Date

Katy Trail Community Health
Patient Financial Information

IMPORTANT NOTICE TO OUR PATIENTS-PLEASE READ CAREFULLY

- Our Sliding Fee Discount Program is designed to help you pay for medical, dental, and behavioral health services provided by KTCH. If you would like to apply for our sliding fee discount program, please ask the front desk for a sliding fee program application or request an appointment with one of our Care Coordinators. You must complete the application and provide proof of income to be certified for the sliding fee discount prior to any appointment that you would like the sliding fee to apply.

- Your child may be eligible for a Medicaid program so please ask for an appointment with one of our Care Coordinators to explore this option.

- Your payment today may be by cash, check, or credit / debit card. Your minimum co-pay is due at the time of check-in or your appointment will be rescheduled. The only exception will be when your medical/dental condition is considered an emergency which will be determined by our triage nurse/dental coordinator using guidelines established by our Chief Medical /Dental Officer.

- If you participate in a health insurance network, Katy Trail will be happy to file the insurance claim on your behalf. It is your responsibility to pay the balance of any fees for services not covered under your insurance plan upon receipt of the bill or as agreed upon in your payment plan. Should you foresee needing financial assistance to pay this balance; you must complete the sliding fee application and provide proof of income before the time of service to be certified for the slide at that time.

- If you do not participate in a health insurance network & have income over 200% of the poverty level, a deposit of $130 will be required for services you are receiving today. **You will also receive a bill for any fees in excess of your deposit.** Should the fees for medical service be less than your deposit, the difference will be refunded to you. It is your responsibility to pay the balance of any fees for services upon receipt of the bill or as agreed upon in your payment plan. **Initial:** _____

Katy Trail firmly believes that a good provider/patient relationship is based upon understanding and good communications. The above information was provided to avoid any misunderstandings. Questions about financial arrangements should be directed to our billing office at 1-877-733-5824 ext. 808. By signing below as the patient or other patient representative, you acknowledge that you have read this Patient Financial Information sheet and agree to the terms stated.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Witness Date