ReGenesis Health Care

REGISTRATION FORM

1a **Patient Name** _____
Last *First* Middle

1b **If a minor**_____
Mother's Name/Legal Guardian *Relationship* *Father's Name/Legal Guardian* *Realtionship*

Date of Birth _____ **Age** _____**Social Security Number**_____

2 **Emergency Contact** _____ Phone# _____
Relationship to Patient _____

3 **Sex:** ( )Male ( )Female ( )U

Gender: ( )Male ( )Female ( )Transgender Male ( )Transgender Female ( )Other ( )Refuse to report

Sexual Orientation: ( )Lesbian, gay or homosexual ( )Straight or heterosexual ( )Bisexual

( )Something else(please specify)_____ ( )Unknown ( )Refuse to report

4 **Mailing Address**_____ **Apt. #** _____

City _____ County _____ State _____ Zip Code _____

Phone # Home _____ Cell _____ Best way to reach you? □Home □Cell

5 **Martial Status** □Single □Married □Divorced □Widowed □Separated □Life Partner □Legally Separated □Unknowr

6 **Language** □Chinese □English □French □German □Italian □Japanese □Other □Sign Language □Spanish □Unreported/Refused to Report

7 **Race** □American Indian or Alaska Native □Asian □Black/African-American □Native Hawaiian □Other Pacific Islander □Unreported/Refused to Report □White

8 **Ethnicity** □Hispanic/Latino □Not Hispanic/Latino □Unreported/Refused to Report

9 **Housing** □Doubling Up □Homeless Shelter □Not Homeless □Other □ Street □Transitional □Unknown

10 **Agricultural** □ Dependent of Migrant □ Dependent of Seasonal □ Migrant Worker □ Not Agricultural Worker □ Seasonal Worker

11 **Email Address**_____

12 **ReGenesis Health Care Offers an In-house Pharmacy. If you would like your prescription(s) filled at our on site location, please check here ( ). If not, please list preferred pharmacy name, location and phone number:**_____

13 **Do you have an Advance Directive? _____Yes _____NO**
If yes please provide a copy of the information to you healthcare provider to be placed in your medical chart.
inidviduals that you have authorized. Please list below the names of any relatives, as well as their relationship to you, that you authorize ReGenesis Health Care to communicate with regarding your care.

14 **I AUTHORIZE THE SHARING OF MY MEDICAL INFORMATION WITH THE FOLLOWING INDIVIDUALS:**

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Patient(Parent/Guardian)Signature_____ **Date:** _____

15 **PARENT/GUARDIAN INFORMATION**

Name & Relationship of Adult Accompanying Child: :

_____

List persons having permission to obtain medical treatment for your child if you are unable to accompany your child. P must provide picture identification at time of visit.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

16 **How would you like to be contacted regarding appointments, treatment, or other information pertaining to your care?**

____Mail ____Home Phone ____Work Phone

If you have an answering machine, may we leave a nonspecific message regarding appointments, or other information pertaining to your care? ____Yes ____No

If you do not authorize the use of any of these methods, then please list any alternate method we may use in contacting you: _____

Patient(Parent/Guardian)Signature_____ **Date:** _____

17 Are you a Veteran? □ Yes □ No

Annual Household Income _____ Family Size _____ *(for reporting purposes only)*

18 **Employment Status** □Full-time □Part-time □Unemployed/None **Student** □Full-time □Part-time □Not in School

Employer Name: _____

Employer Address:_____

19 **INSURANCE INFORMATION** ***(please provide copies of all medical insurance cards)***

*Co-payments are required at time of visit and/or payment for services not covered by insurance.

□Private Insurance □Self Pay □Workers Comp □Disabled □Other

Plan Name (Primary Insurance)_____

Certificate/Plan Number _____ Effective Date _____

Plan Name (Other Insurance) _____

Certificate/Plan Number _____ Effective Date _____

20 **GUARANTOR INFORMATION** ***(person financially responsible for any patient balances)*** **[ ]check if same as patient**

Name _____ Date of Birth _____

Relationship to Patient _____ Social Security # _____

Mailing Address _____

City _____ State _____ Zip _____

Phone # Home _____ Cell _____ Best way to reach you? □Home □Cell

21 **SUBSCRIBER INFORMATION** ***(person who carries the insurance)*** **[ ]check if same as patient**

Name _____ Date of Birth _____

Relationship to Patient _____ Social Security # _____

Mailing Address _____

City _____ State _____ Zip _____

Phone # Home _____ Cell _____ Best way to reach you? □Home □Cell

*I authorize the release of any required medical information from my record to the above insurance company in order to process my claim. I understand that I am responsible for any charges not covered by insurance or other forms of benefits.

_____

Signature of Patient, Guardian or Legal Representative / Date

ReGenesis Health Care

My Family. My Doctor. My Choice.

*As your **PATIENT CENTERED MEDICAL HOME**, we are committed to your life-long health and wellbeing*

Patient Centered Medical Home means that we are available during and after office hours:

- We want you to see the same provider at every visit; however, your own provider may be fully booked, therefore, we will assist you in seeing one of our other providers to avoid delays.
- We routinely have evening hours at some of our locations.
- We keep several appointments open for each provider for same day appointments.
- We offer appropriate medical advice and information during office hours.
- We have a Nurse on Call (864-582-2411) afterhours and weekends when the office is closed.

Patient Centered Medical Home means we use "Evidenced Based Care"for short and long term illnesses:

- We care for short term illnesses and mange long-term chronic diseases. We also offer Dental Services, in addition, to offering prescription services through our Pharmacy.
- Behavioral Health Counseling (BHC) is offered to New Patients who express an interest in seeing a ReGenesis Health Care (RHC) Behavioral Health specialist by referral after an initial NEW PATIENT visit has been completed with an RHC Primary Care Provider.
- BHC is also available to active, established patients by requesting a referral from their PCP during a visit, by phone message to their PCP/nursing staff, or requesting an appointment from the front desk staff.

Patient Centered Medical Home means we organize your health care outside our practice:

- We keep track of Lab Tests, Imaging Studies, and Referrals ordered for you.
- We help you make specialists appointments and monitor to see if you have gone to these appointments.
- We have processes in place to ensure all test results come back to your provider for review.
- We obtain records from ER visits and Hospital stays so your records remain updated. If you need to obtain your medical records you may contact the Health Information Department at 864-582-2817 ext. 3615.

Patient Centered Medical Home means we expect you to be an active participant in the self-management of your healthcare:

- You will agree to keep all scheduled appointments at our office, as well as with any specialists.
- You will be open and honest in providing your doctor with your health related information.
- You will participate in developing an action plan to assist with self-management care.
- You will notify us if your insurance, prescription coverage or financial situation changes.

Patient Centered Medical Home means we actively seek to improve quality of our services:

- We respect your privacy and keep your patient health information confidential.
- We ask your input for improvement efforts through suggestion boxes and satisfaction surveys.
- We are committed to providing quality, affordable care to everyone regardless of their ability to pay and no patient will be denied health services due to an individual's inability to pay for such services.
- To ensure access to care, RHC provides services at a discounted (sliding fee) rate to patients whose total household income falls within certain parameters of the Federal Poverty Guidelines as published by the US Department of Health and Human Services. Any patient desiring to apply for health insurance can visit **www.healthcare.gov** to review their options.