Please email to info@neohealth.org and include which location you are to be seen at. Please type your name in each signature field as your "electronic signature".

New Patient Registration Form

As a Federally Qualified Health Center, NeoHealth is required to collect demographic information regarding the patients we serve. The information you provide is confidential. Please check Not Reported/Refused if you do not wish to answer a specific question. Thank you for choosing NeoHealth as your health care provider.

Section 1: Patient Information

First Name: _____ **Middle Name:** _____ **Last name:** _____

Suffix: _____ **Social Security Number:** _____ **Sex:** ☐ Male ☐ Female

Date of Birth: _____ **Marital Status:** ☐ Single ☐ Married ☐ Other _____

Street Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Email:** _____ **Primary Phone:** ☐ Home ☐ Cell ☐ Work

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

How did you learn about NeoHealth? ☐ Friend/Family referral ☐ Physician referral ☐ Phone Book ☐ Online ☐ Newspaper Advertisement ☐ Radio Advertisement ☐ Other _____

Primary Language: ☐ English ☐ Spanish ☐ Sign Language ☐ Other _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ African American ☐ Caucasian ☐ Native Hawaiian or Other Pacific Islander ☐ Other _____

Ethnicity: ☐ Latino/Hispanic ☐ Non-Latino/Hispanic ☐ Not Reported/Refused

Gender Identity: ☐ Not Reported/Refused ☐ Female ☐ Male ☐ Transgender Female (Male-to-Female) ☐ Transgender Male (Female-to-Male) ☐ Non-Binary (Identifying as any gender other than female or male) ☐ Uncertain ☐ Other _____

Sexual Orientation: ☐ Not Reported/Refused ☐ Heterosexual/Straight ☐ Homosexual/Gay/Lesbian ☐ Bisexual ☐ Uncertain ☐ Other _____

Section 2: Guarantor (Financially Responsible Individual) Information

Guarantor is: ☐ Patient is Guarantor (no need to complete rest of this section) ☐ Person ☐ Company

Patient's Relation to Guarantor: ☐ Child ☐ Parent ☐ Spouse ☐ Employer ☐ Other _____

First Name: _____ **Middle Name:** _____ **Last name:** _____

Suffix: _____ **Social Security Number:** _____ **Sex:** ☐ Male ☐ Female

Date of Birth: _____ **Marital Status:** ☐ Single ☐ Married ☐ Other _____

Street Address: _____ **City:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Primary Language: ☐ English ☐ Spanish ☐ Sign Language ☐ Other _____

Section 3: Family Income and Shelter Information

We request income on all patients for governmental reporting purposes.
If eligible for the Sliding Fee Scale, please complete separate Sliding Fee Application.

Income Period: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Bi-monthly ☐ Quarterly ☐ Annually ☐ Other _____

Gross Income for Period: $_____ **Number of Individuals Income Supports**: ____ **Disabled**: ☐ Yes ☐ No

Homeless Status: ☐ Not Homeless ☐ Homeless Shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Other _____

Worker Status: ☐ Migrant ☐ Not Migrant ☐ Seasonal **Veteran**: ☐ Yes ☐ No

Section 4: Patient Insurance Information

Please allow our staff to copy/scan your insurance card.

Plan 1 Information

Insurance Company: _____

Group Number: _____ **Claim Member ID:** _____

☐ **Use Patient Information** (no need to complete the rest of this section)

Patient's Relation to Subscriber: ☐ Child ☐ Parent ☐ Spouse ☐ Other _____

First Name: _____ **Middle Name:** _____ **Last name:** _____

Suffix: _____ **Social Security Number:** _____ **Sex**: ☐ Male ☐ Female

Date of Birth: _____ **Street Address**: _____ **Apartment Number**:

City: _____ **State**: _____ **Zip Code**: _____ **Phone Number:** _____

Plan 2 Information

Insurance Company: _____

Group Number: _____ **Claim Member ID:** _____

☐ **Use Patient Information** (no need to complete the rest of this section)

Patient's Relation to Subscriber: ☐ Child ☐ Parent ☐ Spouse ☐ Other _____

First Name: _____ **Middle Name:** _____ **Last name:** _____

Suffix: _____ **Social Security Number:** _____ **Sex**: ☐ Male ☐ Female

Date of Birth: _____ **Street Address**: _____ **Apartment Number**:

City: _____ **State**: _____ **Zip Code**: _____ **Phone Number:** _____

Section 5: Alternative Contact Authorization

This authorization allows NeoHealth Providers and staff to communicate information regarding your medical care to the individual(s) you designate. As part of NeoHealth's Patient Privacy Policy, NeoHealth will release your health information only as you specifically authorize. Please check whether you do or do not authorize NeoHealth to release your health information and complete the form.

☐ I do not authorize anyone to receive information regarding my medical care.
☐ I do authorize the Providers and staff of this NeoHealth practice to release information regarding my medical care with the individual(s) listed below.

Contact #1
Name: _____ **Relationship:** _____ **Phone:** _____
☐ Emergencies Only ☐ Appointments ☐ Financial Account ☐ Test Results ☐ All Information
☐ Other: _____

Contact #2
Name: _____ **Relationship:** _____ **Phone:** _____
☐ Emergencies Only ☐ Appointments ☐ Financial Account ☐ Test Results ☐ All Information
☐ Other: _____

Contact #3
Name: _____ **Relationship:** _____ **Phone:** _____
☐ Emergencies Only ☐ Appointments ☐ Financial Account ☐ Test Results ☐ All Information
☐ Other: _____

Section 6: Preferred Pharmacy

Pharmacy Name: _____ **Phone Number:** _____ **City:** _____ **State:** _____

Section 7: Consent to Treat Minor

The Minor Treatment Consent Form gives our providers permission to treat your child when he or she is in someone else's care. Please list the person's name, phone number, and his or her relationship to your child in the spaces provided.

I, _____, the legal parent/guardian of _____ (Minor's Name), grant permission to the following individual(s) to request and approve medical care for the above named minor:

Name: _____ **Relationship to Child:** _____ **Phone:** _____

Name: _____ **Relationship to Child:** _____ **Phone:** _____

Name: _____ **Relationship to Child:** _____ **Phone:** _____

Name: _____ **Relationship to Child:** _____ **Phone:** _____

_____ _____
Parent/Legal Guardian Signature **Date**

_____ _____
NeoHealth Witness Signature **Date**

NeoHealth
NORTHEASTERN OKLAHOMA COMMUNITY HEALTH CENTERS, INC.

Treatment and Payment Authorization

You are responsible for your own bill. As a courtesy, NeoHealth will submit charges to your insurance carrier. If you have no insurance, you will be required to set up payment arrangements with our financial counselor.

- I hereby assign, transfer, and set over to NeoHealth all of my rights, title, and interest to my medical reimbursement benefit under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I, revoking said authorization, give written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

- I, the undersigned, agree to participate in clinical interviews, treatment, and testing as a patient of NeoHealth.

- I authorize treatment for my identified minor or myself. I also understand that examination and treatment may be by a student, intern, or resident under the supervision of a clinician.

_____ _____

Patient/Guardian Signature Date

Notice of Privacy Practices

☐ I have been given, read, and understand the Notice of Privacy Practices of NeoHealth.

☐ I have refused my copy of the Notice of Privacy Practices.

_____ _____

Patient/Guardian Signature Date

_____ _____

Witness Signature Date

NeoHealth
NORTHEASTERN OKLAHOMA
COMMUNITY HEALTH CENTERS, INC.

ACKNOWLEDGMENT OF RECEIPT OF NEOHEALTH WELCOME PACKET

Please initial beside each item that you have received in writing and understand the items contained in the welcome packet. If you at any time have questions please ask for assistance from our front desk employees.

_____ Billing, Payment, and Referral Information and Registration

_____ Patient Rights and Responsibilities

_____ Discount Drug Pricing and Medication Refills

_____ Medication Policy

_____ Patient Centered Medical Home Agreement (PCMH)

_____ Consumer Notice of Health Information Practices (HIPAA)

_____ Notice of Privacy Practice

_____ NeoHealth Sliding Fee Scale Application

_____ NeoHealth Sliding Fee Scale

_____ _____

Patient or Patient's Representative Signature Date

_____ _____

Please Print Your Name Patient's Name

_____

Representative's Relationship to Patient

_____ _____

Verification Signature – NeoHealth Staff Date

For Office Use only

Patient # _____