MAHEC Patient Registration Form

Please complete the following information using black ink. THIS INFORMATION IS CONFIDENTIAL.

☐ Internal Medicine ☐ FHC Biltmore ☐ FHC Cane Creek ☐ FHC Enka/Candler ☐ FHC Newbridge
☐ Ob/Gyn Biltmore ☐ Ob/Gyn Franklin ☐ Women's Care Brevard ☐ Psychiatry ☐ Deerfield ☐ Givens

PATIENT INFORMATION

Name: ______________________ Date of Birth: ______________

Home Address: ______________________ Birth Sex: ☐ Male ☐ Female

City: ______________ State: ________ ZIP: ________ SS#: ______________

Home County: ______________ Email Address: ______________________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

By providing a phone number, mobile phone number, or email address, I authorize MAHEC to contact me or my guardian/legal representative to remind me of appointments, to obtain feedback on my experience at this office, and to provide general health reminders and other information regarding my healthcare.

Special Hearing Needs:

____

Special Vision Needs:

____

Uses Wheelchair: ☐ Yes ☐ No

Speech Impaired: ☐ Yes ☐ No

Veteran Status: ☐ Yes ☐ No

Race (select one):
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ White
- ☐ More than one race

Ethnicity (select one):
- ☐ Hispanic or Latino/a
- ☐ Non-Hispanic or Latino/a

Gender Identity:
- ☐ Male
- ☐ Female
- ☐ Transgender Male
- ☐ Transgender Female
- ☐ Other
- ☐ Choose not to disclose

Sexual Orientation:
- ☐ Lesbian or Gay
- ☐ Heterosexual (or straight)
- ☐ Bisexual
- ☐ Something else
- ☐ Don't know
- ☐ Choose not to disclose

Preferred Language:
- ☐ English
- ☐ Spanish
- ☐ Russian
- ☐ American Sign Language
- ☐ Other: ______________

Marital Status:
- ☐ Single
- ☐ In a relationship
- ☐ Partner
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Special Populations

Migratory ☐ Yes ☐ No

Seasonal ☐ Yes ☐ No

Homeless ☐ Yes ☐ No

Homeless Status (select one):
- ☐ Not Homeless
- ☐ Homeless Shelter
- ☐ Transitional
- ☐ Doubling Up
- ☐ Street
- ☐ Permanent Supportive Housing
- ☐ Other

EMERGENCY CONTACT INFORMATION

Name: ______________________

Relationship: ______________ Phone#: ______________

IF PATIENT IS CHILD (UNDER 18)

Responsible Party Name: ______________________

Relationship: ______________ Phone#: ______________

MRN # ____________________

ANNUAL HOUSEHOLD INCOME BEFORE TAXES

____________________ # of Individuals in Household: ________

The income information above is used for statistical information only and is not used to determine specific patient financial needs.

PRIMARY INSURANCE INFORMATION

Insurance Company: ____________________ Policy ID#: ____________________

Policy Holder's Name: ____________________ Policy Holder's DOB: ____________________

Policy Holder's Relationship to Patient: ____________________ Birth Sex of Policy Holder: ☐ Male ☐ Female

Policy Holder's Address: ____________________

SECONDARY INSURANCE INFORMATION

Insurance Company: ____________________ Policy ID#: ____________________

Policy Holder's Name: ____________________ Policy Holder's DOB: ____________________

Policy Holder's Relationship to Patient: ____________________ Birth Sex of Policy Holder: ☐ Male ☐ Female

Policy Holder's Address: ____________________

ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

I hereby authorize payment of all insurance, Medicaid, and/or Medicare benefits directly to MAHEC and I authorize them to file insurance on my behalf. I also authorize them to release medical and/or account information to my insurance, Medicaid, and/or Medicare carrier as required to satisfy claims. I agree to notify them should my coverage change.

I understand that MAHEC:

- Expects payment on the date of service (if insured, co pays and deductibles are expected on the date of service).
- Accepts cash, checks, debit cards or major credit cards.
- Expects Medicaid, Medicare and all insurance will be filed for me. However, it is my responsibility to know the details of my insurance coverage and provide MAHEC with current and accurate information.
- Will work with me to establish payment plans.
- Provides services and treatment, which are medically appropriate. However, some of these may not be covered by my insurance plan and these will be my responsibility to pay.
- Expects my insurance company to pay within 90 days from the date of service and will bill me directly if the insurance does not pay.
- Expects the parent or guardian to pay for all services rendered to their dependents.
- Expects me to keep appointments and to call at least 24 hours prior, if I need to cancel. I understand that failure to do this may result in being discharged from the practice.

I have read and understand the above.

Patient or Parent/Guardian Signature: ____________________ Date: ____________________

Note: Failure to sign does not relieve you of the above expectations.

MRN # ____________________

CONSENT FOR TREATMENT

I voluntarily consent to routine services, medical treatment(s), diagnostic radiology procedure(s), diagnostic lab(s), behavioral health services, and services offered by lay health workers (e.g. doula, community health worker, peer support specialist) as deemed necessary by the healthcare providers treating me at any MAHEC facility. I voluntarily consent to allow MAHEC to seek emergency medical care from a physician or hospital, if needed. I understand that diagnostic procedures may include but are not limited to lab tests on blood, urine, and tissue, including drug screenings. I understand that diagnostic radiology procedures include but are not limited to x-ray, ultrasound, and/or mammography. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may cause injury or even death. I understand I have the right to ask questions about my treatment and/or procedures and the right to refuse any treatment or procedure. I agree to notify my provider of my concerns.

Patient or Parent/Guardian Signature: ____________________ Date: ____________________

ALTERNATIVE CONTACT AUTHORIZATION

I authorize MAHEC to discuss medical and financial information concerning the care and services provided to me with the individuals listed below:

Contact #1

Name: ____________________

Relationship: ____________________ Phone#: ____________________

Contact #2

Name: ____________________

Relationship: ____________________ Phone#: ____________________

Contact #3

Name: ____________________

Relationship: ____________________ Phone#: ____________________

NOTICE OF PRIVACY ACKNOWLEDGMENT

I have been given the opportunity to read MAHEC's Notice of Privacy Practices, and my questions concerning the Notice have been answered. I understand if I choose not to sign this acknowledgment, MAHEC will continue to provide services to me and will use and disclose my Protected Health Information (PHI) in accordance with MAHEC's Notice of Privacy Practices.

Patient or Parent/Guardian Signature: ____________________ Date: ____________________

FOR OFFICE USE ONLY

Primary Care Provider: ____________________

Copy of insurance card obtained? ☐ Yes ☐ No

SLIDING SCALE DISCOUNT PROGRAM

Compassionate financial support

Thank you for applying to our Sliding Scale Discount Program!

These documents will need to be turned in before your application can be processed:

- Completed Application
- Proof of Income

Please return all documents to your Patient Financial Advocate within 30 days of your first appointment.

Family Health Centers and Internal Medicine
Financial Advocate
Phone: (828) 771-3507
Fax: (828) 407-2640

Mailing Address:
123 Hendersonville Rd
Asheville, NC 28803

Ob/Gyn Specialists
Financial Advocate
Phone: (828) 771-5443
Fax: (828) 407-2639

Mailing Address:
119 Hendersonville Rd
Asheville, NC 28803

Center for Psychiatry and Mental Wellness
Financial Advocate
Phone: (828) 771-3460
Fax: (828) 820-8327

Mailing Address:
125 Hendersonville Rd
Asheville, NC 28803

Dental Health Centers
Financial Advocate
Phone: (828) 398-5918
Fax: (828) 552-8691

Mailing Address:
123 Hendersonville Rd
Asheville, NC 28803

If you have any questions regarding this program, please feel free to contact your Patient Financial Advocate at the numbers listed above.

Thank You!

MAHEC

Sliding Scale Discount Program

Compassionate financial support

Sliding Fee Discount Application

It is the policy of MAHEC to provide essential services for Medical, Behavioral Health, and Dental Care regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all essential services provided and billable by MAHEC. Services performed by outside organizations and equipment that is purchased from outside companies, including outside laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services, will not be covered under this policy. This form must be completed every 12 months or if your financial situation changes.

PATIENT NAME			DATE OF BIRTH
STREET ADDRESS			
CITY	STATE	ZIP	PHONE

Please list spouse and dependents

Name	**Date of birth**	**Needs Sliding Scale**	**Current MAHEC patient**
		❑ Yes ❑ No	❑ Yes ❑ No
		❑ Yes ❑ No	❑ Yes ❑ No
		❑ Yes ❑ No	❑ Yes ❑ No
		❑ Yes ❑ No	❑ Yes ❑ No
		❑ Yes ❑ No	❑ Yes ❑ No
		❑ Yes ❑ No	❑ Yes ❑ No

Annual Household Income for all working adults

Source	Self	Spouse	Other	Total
Last two pay stubs, tax form with schedule C if you are self-employed, or letter from employer				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other other miscellaneous sources				

NOTE: Copies of tax returns, pay stubs, or other information verifying income are required before a discount is approved.

I certify that the family size and income information shown above is correct.

Name (please print) ______________________________ **Date** __________

Signature ____

Office Use Only

Approved by: ______________________________

Date approved: ______________________________

Family size: ______________________________

Income: ______________________________

Approved discount: ______________________________

Date received signed agreement: ______________________________

Verification Check List	**Yes**	**No**
Identification/Address: Driver's license, utility bill, employment ID, or		
Income: Prior year tax return, two most recent pay stubs, or other		