



REGISTRATION AND CONSENT

PATIENT'S PERSONAL INFORMATION

Please PRINT AND complete ALL sections below!

Name (Last) _____ (First) _____ (Middle Initial) _____

Date of Birth ____ / ____ / ____ Social Security ____ - ____ - ____

Address _____ Apt.# ____ City _____ State _____ Zip _____

Email _____

CONTACT INFORMATION

I authorize Dayspring to contact me using the following numbers for voice mail, text or email

Cell Phone (____) _____ Home Phone (____) _____ Work Phone (____) _____

Preferred Contact Method:(circle) phone text Email I do not want voice, text or email messages.

GENERAL INFORMATION

Sex:
 Male Female
 Transgender Male (Female to Male)
 Transgender Female (Male to Female)
 Choose Not To Disclose

Race:
 White
 Black/African American
 American Indian/ Alaskan
 Asian
 Other _____

What language do you speak?
 English
 Spanish
 Other _____

Marital Status:
 Single Married
 Divorced Widowed

Are you a Veteran?
 No
 Yes

Orientation:
 Straight (not lesbian or gay)
 Lesbian/ Gay Bisexual
 Don't know Choose Not To Disclose

Ethnicity:
 Non-Hispanic
 Hispanic/ Latino
 Refused to Report/ Unreported

Do you live in public housing?
 No
 Yes

PATIENT'S INSURANCE INFORMATION

What kind of Insurance do you have? Medicaid Medicare/Supplement
 Commercial No Insurance

Name of Insurance _____ PO Box _____ City _____ State _____ ID# _____

RESPONSIBLE PARTY FOR INSURANCE

Relationship to Patient: Self Spouse Child Other: _____

Name (Last) _____ (First) _____ (Middle Initial) _____

Date of Birth ____ / ____ / ____ Social Security # ____ - ____ - ____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

SLIDING FEE

Dayspring provides assistance with medical payments for those who are un(der)insured.

Please check if you... would like more information about Dayspring's assistance program (Sliding Fee)
 decline information about Dayspring's assistance program (Sliding Fee)

PREFERRED PHARMACY/ PROVIDER

Pharmacy: _____ Dayspring Provider: _____

IF REFERRED: PROVIDER/ SERVICE

Referred for: _____ Referring Provider: _____

EMERGENCY CONTACT

Name _____ Relationship _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Phone _____ Email _____



REGISTRATION AND CONSENT

NOTICES AND CONSENTS INITIAL

CONSENT FOR INTEGRATED CARE AND TREATMENT: Dayspring is dedicated to providing primary care and mental health services to our patients. Dayspring patients may be referred from one provider to other health care specialists within Dayspring’s treatment team. Members of the treatment team will share clinical information with each other as clinically necessary. I hereby authorize and consent for all providers employed by DFHC to use diagnostic and treatment procedures they deem necessary for proper medical and behavior health management. The clinic, its medical staff and employees are hereby released from any liability for the results of such treatment. I understand, that if I am 16 years of age or older, I may consent for mental health services. If I am 18 years of age or older, I may consent for all other health services; otherwise my parent or legal guardian will need to consent for services.

NOTICE OF PRIVACY: I have received a copy of DSFHC notice of privacy practices. Information about patients will NOT be given to anyone outside Dayspring Family Health, including family and friends, unless the patient (parent or legal guardian, if a minor) gives written permission or in situations as specified in the Privacy Notice. To facilitate the patient’s treatment plan, Dayspring is authorized to release health records to specialists and/or care teams for referral purposes. Dayspring is also authorized to release health records to the patient’s insurers. Patients may consent to release his/her information if the patient is 16 years or older for behavioral health care and 18 or older for primary care.

FINANCIAL AGREEMENT: I authorize DFHC to bill my insurance for services rendered. I also authorize the release of medical and behavioral health information to my insurers. I understand that if my insurance or other benefits do not cover the services I receive, I am responsible for payment of my account. I authorize payment of my medical and behavior health benefits by my insurance, Medicare, or Black Lung to Dayspring.

BEHAVIORAL HEALTH FEE SCHEDULE: If I were to be referred to Dayspring’s Behavioral Health staff, I understand the following is the fee for service for Behavioral Health services:
 Evaluation (90791) \$167 30 min(90832) \$81 15 min (96150) \$25

TITLE VI THE CIVIL RIGHTS ACT OF 1964: I have received a copy of the Title VI form and information regarding discrimination against race, color, or national origin.

NOTICE OF PATIENT RIGHTS & RESPONSIBILITY: I have been given notice of my patient rights and responsibility and understand that I may request a copy at any time. Included is an Evacuation Plan.

AUTHORIZATION FOR RELEASING RECORDS, PRESCRIPTIONS, ORDERS, SUPPLIES, AND BILLING INFORMATION

- No One – Please do not release my records, prescriptions, orders, or supplies to anyone.**
- I authorize DFHC to release (circle: Medical Records, Prescriptions, Supplies, Billing info) to the following people:

Name	Relationship	Expiration Date
_____	_____	_____
_____	_____	_____

(authorization will be effective for 1 year unless indicated otherwise)

CERTIFICATION OF INFORMATION

By signing this form, (parent or legal guardian signature, if required) I agree that I have read and/or explained this consent form, that I understand it, and that all my questions have been answered. I certify my demographic information given is correct and agree to be truthful in providing information. Thus, I hereby request, agree, and consent to evaluation and treatment for myself and/or my child(ren) as set forth above, including any studies or procedures that Dayspring staff deem necessary. If signing as parent or guardian or authorized representative, I hereby represent and warrant that I am legally empowered and entitled to make such decisions.

Patient Name _____ Date of Birth _____

Signature of Patient / Authorized Representative _____ Relationship _____ Date _____