REGISTRATION AND CONSENT - GENERAL

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

Marital Status:
☐ Single ☐ Married
☐ Divorced ☐ Widowed

Orientation:
☐ Straight (not lesbian or gay)
☐ Lesbian/ Gay ☐ Bisexual
☐ Don't know ☐ Not Sharing

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

Ethnicity:
☐ Non-Hispanic
☐ Hispanic/ Latino
☐ Not Sharing / Unreported

What language do you speak?
☐ English
☐ Spanish
☐ Other _____

Are you a Veteran?
☐ No
☐ Yes

Do you live in public housing?
☐ No
☐ Yes

Fed Poverty Guidelines:
Which option below best represents your household income compared to the Federal Poverty Guidelines.
☐ 100% and below
☐ 101-150%
☐ 151-200%
☐ over 200%
☐ I don't know
☐ Not Sharing

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 - GENERAL

NOTICES AND CONSENTS	INITIAL
CONSENT FOR INTEGRATED CARE AND TREATMENT: Dayspring is dedicated to providing primary care, dental 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 Dayspring 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 Dayspring Health's notice of privacy practices. Information about patients will NOT be given to anyone outside Dayspring 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 Dayspring 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 that there may be a fee associated with these services. Evaluation (90791) $200 30 min (90832) $134 45 min (90834) $153	
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 Dayspring to release (circle: Medical/ Dental Records, Prescriptions, Supplies, Billing) 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) or my guardianship 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