OPEN DOOR
FAMILY MEDICAL CENTERS

Patient Registration and Attestation Form

Parent /Legal Guardian or Patient*:* _____ **DOB:** _____

2nd Parent/Legal Guardian, if applicable: _____ **DOB:** _____

Gender __**M** __**F** **SS#:** _____ **Email:**_____

Address:_____
Apt #

_____
Town **State** **Zip Code**
Home Phone: _____ **Work Phone** _____**Cell Phone:** _____

Veteran ☐**Yes** ☐**No** **Insurance** ☐**Yes** ☐**No** **Card:** ☐**Yes** ☐**No**

Please list all children under 18 years of age who are Open Door patients:				**Relationship to the Above Individual**	**Insurance Card**
NAME	**DOB**	**M**	**F**	**Relationship**	☐**Yes** ☐**No**
NAME	**DOB**	**M**	**F**	**Relationship**	☐**Yes** ☐**No**
NAME	**DOB**	**M**	**F**	**Relationship**	☐**Yes** ☐**No**
NAME	**DOB**	**M**	**F**	**Relationship**	☐**Yes** ☐**No**

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to be sent directly to Open Door Family Medical Centers, Inc., or its individual providers for services rendered for me and all my identified children under 18 years of age as listed above.

Signature of Patient/Guardian _____ **Date**_____

FINANCIAL AGREEMENT: I understand and agree that I am ultimately responsible for the balance for myself and all my identified children under 18 years of age as listed above for any professional services rendered. Should my insurance claim be denied for lack of eligibility or termination of coverage, I understand that I will be held responsible and intend to make payment for any balance due in those instances.

Signature of Patient/Guardian _____ **Date**_____

AUTHORIZATION OF TREATMENT: I hereby give permission to the staff of the Open Door Family Medical Centers, Inc., to provide medical and dental treatment, vaccine administration which is transmitted to the NYS Registry, and access to prescriptions information from Sure Scripts and release medical information for reimbursement purposes for myself and all my identified children under 18 years of age as listed above. I have received a copy of the PATIENT BILL OF RIGHTS, 24 HOUR ON-CALL POLICY, HEALTH CARE PROXY, LIVING WILL, PAIN MANAGEMENT, AND HIPAA NOTIFICATION.

Signature of Patient/Guardian: _____ **Date**_____

Sliding Fee Discount Program Eligibility:

☐ **I am not interested in disclosing my financial information, therefore my family and I are not eligible for the sliding fee discount program.**
☐ **Attached is my income documentation– tax records, paystubs, employer letter, etc.**
☐ **I have no documentation to verify my income.**

(Please check all that apply):
☐ **I get paid in cash.**
☐ **I do not get paychecks or pay stubs.**
☐ **I did not file a tax return last year.**
☐ **I cannot get a letter from my employer.**

Family size (individuals in your household that you are financially responsible for) including yourself:_____

Household Income amount below (choose one box):

Yearly	**Monthly**	**Biweekly**	**Weekly**
$	**$**	**$**	**$**

I certify that the above information is true and correct. I understand that this information is to be used to determine eligibility for the center's sliding fee discount program. I understand that Open Door may verify information on this form. I also understand that if I intentionally misrepresent my family's income, I will not be eligible to receive services at a discounted rate.

Signature of Patient/Guardian:_____ **Date:**_____ *(2/15/2017)*