TERRY REILLY
Your Health. Our Mission.

Terry Reilly Health Services does not discriminate in its services, treatment, program, activities or employment regardless of race, color, religion, national origin, age, physical or mental disability, veteran status, or sex, including gender identify and sexual orientation.

PATIENT REGISTRATION FORM

PATIENT INFORMATION					
Name:					Date:
Birth Date:	Gender:		Social Security #:		
Physical Address:		City:	State:		Zip:
Mailing Address:		City:	State:		Zip:
Home Phone:	Cell Phone:		Work Phone:		
Email Address:		Preferred Name:			
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated ☐ Partner					

RESPONSIBLE PARTY				
☐ Same as Patient ☐ Responsible Party's Name:				
Birth Date:	Gender:		Social Security #:	
Address:		City:	State:	Zip:
Home Phone:	Cell Phone:		Work Phone:	
Email Address:		Relationship to Patient:		

EMERGENCY CONTACT INFORMATION		
Name:		Phone:
Address:	Relationship to Patient:	

EMPLOYER INFORMATION	
Check one: ☐ Part Time ☐ Full Time ☐ Self-Employed ☐ Unemployed ☐ Retired	
Employer Name:	
Employer Address:	Employer Phone:

INSURANCE INFORMATION		
Primary Medical Insurance:		Policy Number:
Insured Party Name:		Group Number:
Insured Party Birth Date:	Relationship to patient: ☐ Self ☐ Spouse ☐ Parent	
Secondary Medical Insurance:		Policy Number:
Insured Party Name:		Group Number:
Insured Party Birth Date:	Relationship to patient: ☐ Self ☐ Spouse ☐ Parent	
Dental Insurance:		Policy Number:
Insured Party Name:		Group Number:
Insured Party Birth Date:	Relationship to patient: ☐ Self ☐ Spouse ☐ Parent	
☐ No Health Insurance		

BOISE CLINIC PATIENTS
Do you live in Boise City Limits? ☐ Yes ☐ No
Is the patient a single mother with children 17 years or younger living with her? ☐ Yes ☐ No
Does anyone in your household have a disability? ☐ Yes ☐No If yes, how many people?

CDBG: FOR STAFF USE ONLY (REQUIRED)	Date:	# of Children:
☐ CDBG Eligible ☐ CDBG Ineligible	Staff Cert Initials:	

Terry Reilly receives grant funding from multiple sources including Community Development Block Grant, Council on Domestic Violence, and United Way. Statistical information collected is voluntary and is not a condition for receiving services.

As a Federally Qualified Health Center, we are <u>required</u> to collect the following information for statistical purposes only. No individual information is submitted. Your cooperation helps us improve healthcare for all.			
Family Income	Our annual household income before taxes is: $_____. There are _____ people in my household.		
	Check here if you decline to provide income information: ☐		
Ethnicity	Are you Hispanic/Latino?	☐ Yes	☐ No
Race	☐White ☐Black/African American ☐Asian ☐Hawaiian Native ☐Pacific Islander ☐ American Indian/Alaska Native ☐ Other		
Language	What is your preferred language, including sign language? _____		
Farmworkers	**In the past two years**, have you or a member of your family worked in Agriculture (fields, orchards, etc.) as the primary source of income?	☐ Yes	☐ No
	If yes, does this person change residence as part of his work?	☐ Yes	☐ No
	Have you or a member of your family stopped migrating to work in Agriculture due disability or old age?	☐ Yes	☐ No
Veterans	Are you a Veteran?	☐ Yes	☐ No
Sexual Orientation	☐ Straight ☐ Lesbian, Gay or Homosexual ☐ Bisexual ☐ Other ☐ Unknown ☐ Choose not to disclose		
Gender Identity	☐ Male ☐ Female ☐ Transgender (Male/Female to Male) ☐ Transgender (Female/ Male to Female) ☐ Other ☐ Unknown ☐ Choose not to disclose		

Reduced Fees:	Are you interested in applying for our reduced fees (even if you are insured)?	☐ Yes	☐ No

HEALTHCARE FOR THE HOMELESS
If you do not own a home or rent, how would you describe your living arrangements?
I am temporarily living in: ☐ Shelter ☐ Transitional Housing ☐ Street/Car/Camping ☐ Drug Treatment Center ☐ Friends/Relative - How long? _____ ☐ Other _____

ACKNOWLEDGEMENTS
Consent: I give consent for Terry Reilly to conduct a medical, dental, and/or mental health evaluation and make treatment recommendations for myself or my dependent. I further acknowledge I have been given the opportunity to read and understand the general consent to treatment policy and I agree with its content.
Financial Responsibility/Release of Information: I understand that I am responsible for all charges incurred, including deductibles, co-payments, and non-covered services. I understand that any payment made today is applied to balance and may not cover all the services I receive. I understand that Terry Reilly may bill my insurance as a courtesy to me, and I authorize the release of any medical, dental, or mental health information necessary to process my insurance claim. I also authorize payment of medical, dental, and/or mental health benefits to Terry Reilly. Some insurance policies require compliance with additional requirements such as pre-authorizations or Healthy Connection referrals. I agree to cooperate with these efforts and understand that I am responsible for all non-covered expenses. Unpaid accounts may be turned to collections, reported to the Credit Bureau, and/or result in termination of care at Terry Reilly. I also understand that if I apply for special programs or other assistance, my information may be shared with those programs and their auditors.
Accuracy and Truthfulness of Information: The information I have provided is complete and accurate. I understand intentionally providing false information may exclude me from services at Terry Reilly, and I may be billed for discounts received under false pretenses.
Patient Rights and Responsibilities: I have been given access to, and may have a copy of, the Terry Reilly Patient Rights and Responsibilities. If I believe these rights have been violated, I may file a complaint.
Notice of Privacy Practices: I have been given access to, and may have a copy of, the Terry Reilly Notice of Privacy Practices. If I choose not to, or am unable, to sign, a staff member will sign indicating he or she has provided me with access to a copy of this Notice.
Health information: Your health information may be shared across our dental, medical and behavioral health divisions.
Idaho Health Data Exchange: Terry Reilly is a proud partner with IHDE to provide effective coordination of your health care services. This is a secure statewide internet-based health information exchange with the goal of improving the quality and coordination of health care in Idaho.
Sliding Fee: Terry Reilly Health Services may access my information from the Idaho Department of Health and Welfare's Partner Data Access Portal (PDAP) to determine my eligibility for discounts on healthcare.
Patient/Representative Signature_____ Date _____ If Representative, Relationship to Patient: _____