HAHC, INC.
HYNDMAN AREA HEALTH CENTER

Patient Registration Form

Hyndman Family Health Center
144 5th Avenue
Hyndman, PA 15545
814.842.3206 (P)
814.842.3746 (F)

Patient Demographic Information

LAST	FIRST	MIDDLE	MAIDEN OR SUFFIX

Address

PO BOX/STREET	ZIP CODE	CITY	STATE	APT #

HOME PHONE NUMBER	CELL PHONE NUMBER	SOCIAL SECURITY NUMBER	GENDER IDENTITY (CIRCLE ONE): ☐ MALE ☐ FEMALE ☐ OTHER ☐ TRANSGENDER MALE/FEMALE TO MALE ☐ CHOOSE NOT TO DISCLOSE TRANSGENDER FEMALE/MALE TO FEMALE ☐

EMAIL ADDRESS:	RACE (CIRCLE ONE): WHITE ☐ BLACK/AFRICAN AMERICAN ☐ AMERICAN INDIAN ☐ ALASKA NATIVE ☐ ASIAN ☐ PACIFIC ISLANDER ☐ UNREPORTED/REFUSED ☐

MARITAL STATUS (Circle One) SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPERATED ☐ LIFE PARTNER ☐	BIRTHDATE	ETHNICITY (CIRCLE ONE): HISPANIC LATINO OTHER UNREPORTED/REFUSED select one

ALLERGIES (PLEASE CIRCLE ONE): YES ☐ NO ☐ **IF YES, PLEASE LIST ALLERGIES:**	ARE YOU A VETERAN (CIRCLE ONE)? YES ☐ NO ☐

SEXUAL ORIENTATION (CIRCLE ONE):
STRAIGHT ☐ LESBIAN OR GAY ☐ SOMETHING ELSE: _____ ☐ DO NOT KNOW ☐ CHOOSE NOT TO DISCLOSE ☐

Emergency Contact Information

CONTACT NAME	RELATIONSHIP	HOME PHONE NUMBER	CELL PHONE NUMBER
SECOND CONTACT NAME	RELATIONSHIP	HOME PHONE NUMBER	CELL PHONE NUMBER

EMPLOYMENT INFORMATION

OCCUPATION	EMPLOYER'S NAME	PHONE NUMBER

Employer Address

PO BOX/STREET ADDRESS	ZIP CODE	CITY	STATE

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Please complete the below information to the best of your ability. We will scan your insurance and photo identification to verify your insurance.

Responsible Party's Primary Insurance Information			
LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE
SOCIAL SECURITY NUMBER	OCCUPATION	SEX (CIRCLE ONE) MALE FEMALE	
RESPONSIBLE PARTY'S EMPLOYER'S NAME	EMPLOYER'S PHONE NUMBER	RELATIONSHIP TO PATIENT	
EMPOYER PO BOX/STREET ADDRESS	ZIP CODE	CITY	STATE

Medical Insurance Information			
PRIMARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER	INSURANCE PHONE NUMBER
INSURANCE PO BOX/STREET ADDRESS	ZIP CODE	CITY	STATE
SECONDARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER	INSURANCE PHONE NUMBER

Dental Insurance Information (If applicable)			
PRIMARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER	INSURANCE PHONE NUMBER
INSURANCE PO BOX/STREET ADDRESS	ZIP CODE	CITY	STATE

Prescription Insurance Information (If applicable)			
PRIMARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER	INSURANCE PHONE NUMBER
INSURANCE PO BOX/STREET ADDRESS	ZIP CODE	CITY	STATE
SECONDARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER	INSURANCE PHONE NUMBER

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Please complete the below information to ensure you have your prescriptions ordered in a timely manner.

Patient's Pharmacy Information			
PHARMACY NAME		PHARMACY TELEPHONE NUMBER	
ADDRESS	ZIP CODE	CITY	STATE

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Consent to Obtain External Prescription History Consent From

By authorizing Hyndman Area Health Center Inc., and its affiliated providers, you allow us to view your external prescription history via our electronic medical records system (eClinical Works). This will allow your provider to have information regarding medications you're taking in order to minimize adverse drug reactions.

By accepting this consent, you understand that prescription history from multiple unaffiliated medical providers, insurance companies, and pharmacies may be viewed by my provider and authorized staff, and it may include prescriptions back in time for several years.

This consent will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on your treatment.

By signing this consent form you are agreeing that Hyndman Area Health Center Inc., and its affiliated providers can request and use your prescription medication history from other healthcare providers, insurance companies, and pharmacies.

My signature certifies that I read and understand the scope of my consent and that I authorize access.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Patient's Name Patient's Date of Birth

_____
Print Legal Guardian's Name, if applicable

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Notifications and Alerts

At the Hyndman, Bedford, and Richland Family Health Centers we strive to enable patients to take part in achieving their health care goals. Through our automated voice, text, and email messaging system we keep you informed of upcoming appointments and send you friendly reminders. If you provide your email you will have access to our Patient Portal where you can access your medical history, see upcoming appointments, lab results, and much more. Please select your preferences below:

Checkmark Yes or No Below to receive alerts and Reminders

Email Alerts and Reminders ☐ Yes ☐ No

Text Messaging Alerts and Reminders ☐ Yes ☐ No

Voice Messaging Alerts and Reminders ☐ Yes ☐ No

Preferred number to receive calls ☐ cell ☐ home ☐ work

If yes, when would you like to receive reminders ☐ Morning ☐ Afternoon ☐ Evening

I would like to receive the following type of alerts (Check all that apply):

☐ Appointment Reminders ☐ Lab Results ☐ Health Maintenance Updates ☐ Prescription Confirmations ☐ General Notifications

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Consent, Assignment, and Release Form

1. I _____ give permission for Hyndman Area Health Center, Inc. to give me treatment.
(patient name)

2. I request that payment of authorized benefits is made on my behalf to the Hyndman Area Health Center, Inc. for any services rendered to me by their medical and/or dental providers. I authorize Hyndman Area Health Center, Inc. to release medical and/or dental information to my current insurance company and its agents to determine these benefits or the benefits payable for related services.

I understand that:

- Hyndman Area Health Center will have to send my health information to my insurance company.
- I must pay my share of the costs when I receive my treatment.
- I must pay for the cost of these services if my insurance does not pay after 90 days or if I do not have insurance.

3. I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.
- I may request a copy of HAHC's Notice of Privacy Practice at any time.
- I understand all services are voluntary.

4. I have read the consent to treat or have had this consent read to me.

5. I have been able to ask questions and my questions were fully answered.

_____ _____
Patient's Signature Date

_____ _____
Parent or Guardian Signature Date
(for children under 18)

_____
Print Name

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Health Information and Portability and Accountability Act (HIPAA) Form

Date:	
Patient Name:	Date of Birth:

REQUEST FOR SPECIAL PERMISSION

I understand that my physician may use or disclose my protected health information (PHI) for the purpose of treatment, payment and health care operations. My physician may also disclose information to someone involved in my care or the payment for my care, such as a family member or friend.

I hereby permit HAHC to disclose this information to the following people:

Persons Name	**Relationship to Patient**

Comments or special instructions

_____ _____

Signature of patient or his/her authorized representative Date

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Hyndman Area Health Center Electronic Medical Records Opt-In Form

Overview

At Hyndman Area Health Center our mission is to promote your health and wellness by providing you patient centered care that promotes engagement between you and our medical providers helping you have a positive health care outcome. We are truly a Patient First medical facility.

Patients may opt-in to sharing his or her information by indicating below. You may opt-out at any time by completing this form as well.

Sharing of health information is secure and available only for permitted uses between Hyndman Area Health Center and health providers. Sharing of your medical information between healthcare providers is not new, but electronic sharing makes the process quicker and easier.

Benefits

Healthcare professionals involved in your care can easily exchange information about your medical history, treatments, procedures, test results, medications, and more from secure devices. Using this information, Hyndman Area Health Center can coordinate positive healthcare outcomes.

How is my Health Information Protected?

Hyndman Area Health Center protects the privacy and security of your information. We use different security controls to keep your information confidential. The information is available for viewing and use only be approved healthcare providers. These healthcare works must follow all federal and state privacy laws that apply.

The federal Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH), and related regulations, set standards for this.

I, _____ ☐Opt-in ☐Opt-out of having my medical records sent electronically to other healthcare providers.

_____ _____

Signature Date

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Patient Bill of Rights

- To receive quality medical and dental care regardless of your age, sex, religion, national origin, sexual preference, disability, health status or ability to pay.
- To be treated with respect by Hyndman Area Health Center.
- To information contained in your medical record. You also have the right to participate in decisions involving your health care.
- To personal privacy. Any discussion, consultation, examination and/or treatment regarding your care will be done discreetly.
- To confidentiality of your medical record and other information related to your medical condition.
- To be seen in a safe and clean environment.
- To have special needs met, such as an interpreter to help with communication.
- To appoint a person to make health care decisions on your behalf in the event you lose the ability to do so.
- To make advance directives regarding your medical care and have them honored.
- To file a complaint about your care without fear of penalty, to have your complaint reviewed, and when possible, resolved. We strive for patient safety and ensuring Patients First. Should you wish to file a complaint regarding safety or other concerns please contact our Risk Manager, Josh Lang by email at jlang@hyndmanhealth.org or by phone at 814-709-9805.

Your responsibilities as a Patient are:

- To provide, to the best of your knowledge, complete information about your symptoms, past illnesses, medications and other matters relating to your plan of care.
- To schedule and keep doctor/dentist appointments, or call to cancel your appointment if you cannot be there.
- To notify Hyndman Area Health Center of any changes in address, family members or insurance coverage (provide a current copy of insurance card).
- To ask questions when you do not understand explanations about your care or services.
- To be responsible for your actions if you refuse treatment or do not follow your physician's/dentist's instructions.
- To follow the organization's policies.
- To be courteous and considerate of Hyndman Area Health Center personnel and other patients.

This health center receives HHS funding and has federal PHS deemed status with respect to certain health or health-related claims including medical malpractice claims for itself and its covered individuals.

Updated June 29, 2021