



Elevated Community Health

PATIENT REGISTRATION

Patient's Last Name: _____		First Name: _____		Middle Initial: _____	Date of Birth: MM/DD/YYYY	Sex at Birth: M F	Are you a Veteran? Y N
Email Address: _____		Social Security No: _____		Are you currently homeless? Y N			
Mailing Address: _____		Apt/Unit#: _____	City: _____		State: _____	Zip Code: _____	
Physical Address: _____		Apt/Unit#: _____	City: _____		State: _____	Zip Code: _____	
Please let us know where we can leave a detailed voice message: ☐ Cell Phone: _____ ☐ Home Phone: _____ ☐ Work Phone: _____							
INSURANCE, MEDICARE, MEDICAID, CHP+							
	Primary Medical/Behavioral		Secondary Medical/Behavioral Health		Dental		
Name of Insurance		_____		_____		_____	
Insured ID #		_____		_____		_____	
Insurance Group #		_____		_____		_____	
Name of Policy Holder if different from patient: _____					☐ I do not have health insurance		
Preferred Pharmacy		Employment status		Parent/Legal Guardian responsible for under 18 yrs			
Name of Pharmacy: _____		☐ Employed ☐ Unemployed		Printed Name of Parent/Legal Guardian: _____			
Address: _____		☐ Student ☐ Child		Date of Birth: _____			
_____		☐ Seasonal ☐ Retired		Address if Different from Patient: _____			
Phone #: _____		☐ Migratory/Seasonal agricultural worker		_____			
				Relationship to Patient: _____			
HOUSEHOLD INCOME/FAMILY SIZE							
Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed							
Elevated Community Health is dedicated to ensuring that you have access to exceptional, integrated, patient-centered care. As a nonprofit organization, we receive funding from local, state, and federal grant funding sources and are required to collect financial information to continue to receive this funding.							
Please provide your Estimated Household Gross Income (before taxes)							
Weekly \$ _____ Monthly: \$ _____ Annual: \$ _____							
Number of financial dependents living in your household: _____							
PLEASE CIRCLE							
RACE (CIRCLE ONE)		PRIMARY LANGUAGE (CIRCLE ONE)			ETHNICITY (CIRCLE ONE)		
ASIAN INDIAN		AMERICAN SIGN LANGUAGE			MEXICAN		
CHINESE	FILIPINO	ENGLISH			AMERICAN, CHICANO		
JAPANESE	KOREAN	FRENCH			PUERTO RICAN		
VIETNAMESE	OTHER ASIAN	SPANISH			CUBAN		
NATIVE HAWAIIAN	OTHER PACIFIC ISLANDER	OTHER PLEASE SPECIFY: _____			ANOTHER HISPANIC, LATINO/A, OR SPANISH ORIGIN		
AMERICAN INDIAN/ALASKA NATIVE	SAMOAN				NOT HISPANIC, LATINO/A, OR SPANISH ORIGIN		
GUAMANINA OR CHAMORRO		CHOOSE NOT TO DISCLOSE			CHOOSE NOT TO DISCLOSE		
BLACK /AFRICAN AMERICAN					CHOOSE NOT TO DISCLOSE		
WHITE		CHOOSE NOT TO DISCLOSE			CHOOSE NOT TO DISCLOSE		
MORE THAN ONE RACE					CHOOSE NOT TO DISCLOSE		
CHOOSE NOT TO DISCLOSE		CHOOSE NOT TO DISCLOSE			CHOOSE NOT TO DISCLOSE		
					CHOOSE NOT TO DISCLOSE		
IN CASE OF EMERGENCY							
EMERGENCY CONTACT FULL NAME: _____							
RELATIONSHIP TO PATIENT: _____							
EMERGENCY CONTACT PHONE NUMBER: _____							
DOES THIS PERSON KNOW YOU ARE RECEIVING SERVICES AT ELEVATED COMMUNITY HEALTH YES ☐ NO ☐							

PATIENT REGISTRATION FORM CONTINUED (Page 2)

Patient's Last Name:

First Name:

Date of Birth:

HOW DID YOU HEAR ABOUT US

We would love to know how you heard about us.

☐ Word of Mouth ☐ Current Patient ☐ Social Media ☐ County ☐ Other: _____

CONSENTS

To establish care with Elevated Community Health (ECH), please review and sign below.

CONSENT TO TREATMENT I voluntarily consent to in-person and/or telehealth primary care, dental or behavioral health treatment, diagnostic testing, examination, administration of medication, and other medically necessary health care services ordered by medical, dental or behavioral health providers participating in my care. Medical providers include physicians, clinical pharmacists, nurse practitioners, physician assistants, nurses, health educators, and medical technologists. Dental providers include dentist's dental hygienists, and dental assistants. Behavioral health providers include licensed psychologists, social workers, counselors, and registered psychotherapists. I also consent to treatment by health professionals in training under the supervision of a licensed health care professional. I understand that ECH empowers and encourages me to ask questions regarding my care and that I have the right to refuse treatment at any time.

➤ **PATIENTS RIGHTS AND RESPONSIBILITIES** I understand my rights and responsibilities as a patient of ECH.

➤ **FINANCIAL AGREEMENT FOR PATIENT BILLING** I understand that I am financially responsible for all charges incurred for services rendered by this practice, including those not covered or reimbursed by my insurance company. It is my responsibility to provide accurate and current insurance information and to notify the office of any changes. I agree to pay any copayments, deductibles, or non-covered services at the time of service or upon receipt of a billing statement. In the event my account becomes delinquent, I understand that additional fees, including collection costs, may be added to my balance. I authorize the release of necessary medical information to include substance use disorder (SUD) to my insurance company for the purpose of processing claims. **Additionally, my signature below authorizes and directs my insurance carrier, including Medicaid, CHP+, Medicare, Medicare Advantage Plan, and any other health plan to issue payment to ECH for services rendered.**

➤ **NO SHOW POLICY** To best serve all our patients, we want to stress the importance of keeping scheduled appointments and arriving on time. If you realize that you will not be able to arrive on time for a scheduled appointment, please contact us as soon as possible or at least 24 hours prior to the appointment. This allows us to offer your original appointment time to another patient in need. After the second "no-show" in a 6-month period, you can no longer schedule appointments ahead of time, and can only access care on an in person, same day appointment "walk-in" only basis. After the initial same day appointment, you will be able to schedule regular future appointments.

➤ **COMMUNICATION AUTHORIZATION**

- ✓ I AUTHORIZE ECH to contact me via phone, email, SMS text message, patient portal (MyChart), or other vendors for care. I understand that charges from my cell phone carrier may apply. **I may opt-out by contacting ECH if I choose to no longer receive text messages.**
- ✓ I UNDERSTAND the risks of using email and agree that email messages may include protected health information about me, or the patient on this registration. I understand that email should not be used for urgent or emergent situations.

I UNDERSTAND that the protection and privacy of patients, staff, and guests are of utmost importance to ECH and that ECH prohibits the use of audio or video recording within any Elevated Community Health locations.

NOTICE OF PRIVACY PRACTICES (HIPAA)

I have reviewed the Notice of Privacy Practices and understand how information about me may be used and disclosed and how I can get access to this information.

CONSENT TO TREATMENT OF A MINOR

I CERTIFY THAT I AM LEGALLY AUTHORIZED TO CONSENT to medical, dental, behavioral health, and/or other health care services for the minor listed above. I understand that under Colorado law (C.R.S. §§ 13-22-102, 13-22-103, 12-245-203.5, 27-65-103), this authority may lie with a parent, legal guardian, legal authorized caregiver, or in some cases, the minor themselves.

SLIDING FEE SCALE

I understand that Elevated Community Health (ECH) serves all patients regardless of inability to pay. I understand that ECH is a Federally Qualified Health Center (FQHC) that offers discounted medical, dental, and behavioral health services on a Sliding Fee basis. Qualifications are based on your household income, family size, and the federal poverty level. I understand that I can apply at any time.

SIGNATURE OF ACKNOWLEDGEMENT AND CONSENT

I acknowledge and consent to all terms and conditions outlined in this form, I certify that the information provided above is true, accurate, and complete to the best of my knowledge, and understand that providing incorrect or false information may result in termination of services. **By signing below, I acknowledge receipt of the policies listed above and confirm that, as of today's date, I have no further questions.**

PRINTED NAME: _____
Patient/Legal Guardian

SIGNATURE: _____
Patient/Legal Guardian

DATE: _____

Person completing this form if other than the patient Name: _____ **Relationship to patient:** _____

Office use only

Patient ID, _____