ALLIANCE
COMMUNITY HEALTHCARE, INC.
your Ally in life

REGISTRATION FORM

Patient Information

Last Name:	First Name:	MI:	Date of Birth:
SSN:	Preferred #:		Alternate #:
Address:			Apartment #:
City:	State:		Zip Code:

Pronoun(s): She He They Ze
A Pronoun Not Listed No Pronoun Preference

Sex Assigned at Birth: Male Female

E-Mail Address for Patient Portal:

Emergency Contact

Full Name: Phone Number:

Please choose the answer that best fits.

Preferred Language:
☐ English ☐ Spanish/Español
☐ Arabic ☐ French
☐ American Sign Language (ASL)
☐ Other: _____
Language interpretation services needed?
☐ Yes ☐ No

Gender Identity:
☐ Male/Man
☐ Female/Woman
☐ Trans Male/ Trans Man
☐ Trans Female/Trans Woman
☐ Genderqueer/Gender nonbinary
☐ Another Gender:
☐ Decline to Answer:

Select All that Apply
Race:
☐ American Indian/ Alaska Native
☐ Black/ African American
☐ White/ Caucasian

Asian:
☐ Asian Indian ☐ Korean
☐ Chinese ☐ Vietnamese
☐ Filipino ☐ Other
☐ Japanese

Native Hawaiian/Pacific Islander:
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander

Ethnicity:
☐ Non-Hispanic/Latino
☐ Dominican
☐ Cuban
☐ Mexican, Chicano(a)
☐ Puerto Rican
☐ Other Hispanic/Latino

Sexual Orientation:
☐ Lesbian
☐ Gay
☐ Queer
☐ Bisexual
☐ Straight
☐ Something Else
☐ Decline to Answer

Housing Status:
☐ Stable Housing (Not Homeless)
☐ Living on Street
☐ Homeless Shelter
☐ Transitional
☐ Pay day-to-day
☐ Doubling Up (Not Paying Rent)

Veteran:
☐ Yes
☐ No

Migrant Worker:
☐ Yes
☐ No

Annual Income

☐ $0 - $9,570 ☐ $9,571 - $14,355 ☐ $14, 356 - $19,140 ☐ $19,141 - $24,925 ☐ $24,926 - 28,710 ☐ $28,711+

Insurance Information * Please give card(s) to Front Desk* ☐ I do not have insurance.

Insurance Carrier:	Subscriber ID:	Group #:
Sex Listed on Insurance: ☐ Male ☐ Female	Name on Insurance Card:	
Insurance Carrier:	Subscriber ID:	Group #:
Sex Listed on Insurance: ☐ Male ☐ Female	Name on Insurance Card:	

Sliding Fee Application

☐ 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. (Please see attached Sliding Fee Application)
☐ I have no documentation to verify my income. (Please see attached Self-Declaration)

I certify that all the information above is true and correct. I understand this information is required to fulfill grant reporting purposes.
Patient/Parent/Legal Guardian Signature Date

ALLIANCE
COMMUNITY HEALTHCARE, INC.

Alliance Community Healthcare Consent / Authorization Form **MR#:_____**

1. **Consent to Treatment**
   I assign and hereby consent to treatment at Alliance Community Healthcare and authorize each of its physicians, practitioners, health care professionals, employees and members of its medical, dental and behavioral health staff to render care. I understand that the medical care that I receive may include but may not be limited to examination and treatment, vaccine and medicine administration, telemedicine, laboratory tests, diagnostic procedures, emergency treatment and/or other services. Routine testing for HIV (Human Immunodeficiency Virus), HCV (Hepatitis C) and/or HBV (Hepatitis B) will be performed unless otherwise discussed between patient and physician. Patients accept telehealth treatment for appropriate visit types including but not limited to results, follow up appointments, psychotherapy and behavioral health services. Acceptance of family planning services at ACH are solely on a voluntary basis and are not a prerequisite to eligibility for, or receipt of, any other services, assistance from or participation in any other program for your care at our health center. I understand that while Alliance Community Healthcare does accept donations, it is NOT a requirement to receive services.
2. **Consent to Bill**
   If I do not have medical insurance, I understand that I am responsible for all charges incurred and that I will plan to pay or be billed for any outstanding balances in accordance with Alliance Community Healthcare's Patient Financial Policy. If my insurance is accepted, I authorize payment of benefits to Alliance Community Healthcare or will reimburse Alliance if I am paid directly by my carrier. I understand that my insurance may not cover all charges deemed medically necessary by Alliance Community Healthcare and that I am responsible for any part of the charges that are not covered by my insurance and I will be billed directly for those services. I understand the services rendered are on the basis that insurance companies may or may not pay for all, or a portion of charges. The authorization for medical/dental treatment from your Insurance company does not guarantee full payment for the service. That not all insurance companies/third party payors pay for all services, each policy has its own stipulations regarding covered services, or amount of coverage. All insurance companies state that verification of coverage is not a guarantee of coverage or payment. Actual benefits are determined by your insurance company after a claim is received. Patients are personally responsible for knowing and understanding their own insurance policy, eligibility & coverage. I am responsible for knowing if my PCP needs to be updated. Patients are responsible for payment of outstanding deductibles and co-insurance amounts at time of service. Patients are financially responsible for payments of all non-authorized procedures and non-covered services. I understand that no patient will be denied services due to inability to pay. I understand that providing necessary documents listed under sliding fee, will allow my eligibility to be reviewed for grants such as Family Planning and NJ CEED. I understand I have the right to request a Good Faith Estimate when scheduling an appointment at least 3 days in advance.
3. **Consent for Research Studies**
   To better serve our patients, Alliance Community Healthcare conducts research studies on health care, health disparities, and potential health interventions. Please choose one of the options below; the choice you make will NOT affect your ability to receive health care services.
   ☐ I GIVE CONSENT for Alliance Community Healthcare to contact me (including via phone, text or email) about research studies. (Choosing this does not enroll you in any study and you can withdraw your consent to be contacted at any time.)
   ☐ I DENY CONSENT for Alliance Community Healthcare to contact met about research studies.
4. **Patient Rights and Responsibilities:** I have received a copy of the Alliance Rights and Responsibilities.
5. **Patient HIPAA Notice Privacy and Practices:** I acknowledge that I have received a copy of the Alliance HIPAA Notice of Privacy and Practices.
6. **No Show/Missed Appointment and Late Arrival Policy:** I acknowledge that I have received a copy of the Alliance Community Healthcare No Show/Missed Appointment and Late Arrival Policy.

This signature acknowledges all the above as initialed. I am aware that Alliance Community Healthcare may or may not contact me based on the above indicated consent choice regarding research studies I may be eligible for.		
Patient Name (Please Print)	**Patient/Legal Guardian Signature**	**Date**

Alliance Community Healthcare Sliding Fee Application

Patient Information		
Today's Date:	Name of Applicant:	
Date of Birth:	Telephone #:	
Address		
City:	State:	Zip Code:

Family Size	
What is the number of people in your family size (including yourself)?	

Income: Please provide the Annual Income for each of the people in your family size (including yourself).

Name	Relationship	Date of Birth	Income Type (Source)	Annual Income $
1.				
2.				
3.				
4.				
5.				
6.				
Total Income				**$**

Insurance Information	
Do you have any type of insurance that will cover all or a portion of your medical expenses? ☐ **Yes** ☐ **No**	
Insurance Name	**Policy/ID#**
Insurance Name	**Policy/ID#**
I declare under penalty of perjury that the above information is true and correct, and I give Alliance Community Healthcare permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if my income or "family size" should change, I am required to notify Alliance on my next visit to the health center. All the members included above in your family size are automatically approved in ACH's SFDP once you have been approved.	
Applicant Signature:	**Date:**

FOR OFFICE USE ONLY

Reviewed By:_____ Verified Income/or Self-declaration on:_____

Patient & family members are eligible for SFD Tier: ☐A ☐B ☐C ☐D ☐E (100% of Charges)

Eligibility start date: _____ and expires (1) One Year from Eligibility Date.

HIPAA Authorization/Declination Form	
Name of Patient:	
Address:	
Phone Number:	Email Address:
Date of Birth:	Social Security Number:

Name of Guardian or Legal Representative:	
Address:	
Phone Number:	Email:

The following person/organization is hereby authorized to receive my entire medical record (including medical and dental services), treatment record and diagnostic record:

Person/Organization to Receive Information:		
Street Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	

Person/Organization to Receive Information:		
Street Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	

Person/Organization to Receive Information:		
Street Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law. This authorization is valid. A copy, electronic copy, image or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. By signing below, I acknowledge that prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization. I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.		
Patient Signature:	Patient Name:	Date:
Guardian or Legal Representative Signature:	Guardian or Legal Representative Name:	Date:

I decline the option to have my information disclosed with any other person/organization.		
Patient Signature:	Patient Name:	Date:
Guardian or Legal Representative Signature:	Guardian or Legal Representative Name:	Date: