CLARITY HEALTHCARE

PATIENT REGISTRATION FORM

(Please Print)

Today's Date:			Primary Care Provider:		
PATIENT INFORMATION					
Patient's Last Name: First: Middle:		Mr. Ms. Mrs. Miss	Primary Phone Number:	Email Address:	
Is this your legal name? Yes No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: M F
Street Address:		Social Security Number:		Secondary Phone Number:	
P.O. Box:	City:	State:		ZIP Code:	
Patient Occupation:	Patient Employer:			Employer Phone Number:	
School Currently Attending (if child):					
Spouse Information: Name:	Address:			Phone Number:	
Guardian Information: Name:	Address:			Phone Number:	
INSURANCE INFORMATION (Please give your insurance card to the receptionist)					
Person responsible for bill:	Birth date:	Address (if different):		Primary Phone Number:	
Is this person a patient here? Yes No					
Occupation:	Employer:	Employer address:		Employer Phone Number:	
Patients relationship to subscriber: Self Spouse Child Step Child Other					
Please indicate **Primary Insurance**	Medicare	Medicaid	Blue Cross Blue Shield	United Healthcare	Other
Subscriber's Name:	Subscriber's SSN	Birth Date:	Policy #	Group #	Co-payment: $
Name of **Secondary Insurance** (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: Self Spouse Child Step Child Other					
IN CASE OF EMERGENCY					
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):		Relationship to patient:	Primary Phone #	Secondary Phone #	

The following information is requested by the Federal Government in order to monitor compliance with Federal laws prohibiting discrimination against users of Preferred Family Healthcare dba Clarity Healthcare. You are not required to furnish this information, but are encouraged to do so. This information will not be used to discriminate against you in any way, nor will be released except in aggregate form.

(continued on back)

Please Check one box in each of the following categories.

Ethnicity:	**Race:**			**Primary Language:**
Hispanic or Latino	Asian	Other Pacific Islander	White (not Hispanic or Latino)	English
Not Hispanic or Latino	Native Hawaian	Black/African American	Hispanic or Latino (all races)	Other (Specify)_____
		American Indian/Alaska Native	Refuse to Report	

Are you a veteran?:	**Housing Status:**		**Marital Status:**		**Employment Status:**			
YES	Homeless	Transitional Housing	Single	Divorced	***Patient*:**	Part	Full	Unemployed
NO	Own/Rent	Doubling Up	Married	Widow	***Spouse*:**	Part	Full	Unemployed
		Shelter		Legally Separated				

Income Verification Table

Family Size	Income Range	Income Range	Income Range	Income Range
1	$0 - $10,830	$10,831 - $16,245	$16,246 - $21,660	$21,661 +
2	$0 - $14,570	$14,571 - $21,855	$21,856 - $29,140	$29,141 +
3	$0 - $18,310	$18,311 - $27,465	$27,466 - $36,620	$36,621 +
4	$0 - $22,050	$22,051 - $33,075	$33,076 - $44,100	$44,101 +
5	$0 - $25,790	$25,791 - $38,695	$38,696 - $51,580	$51,581 +
6	$0 - $29,530	$29,531 - $44,295	$44,296 - $59,060	$59,061 +
7	$0 - $33,270	$33,271 - $49,905	$49,906 - $66,540	$66,541 +
8	$0 - $37,010	$37,011 - $55,515	$55,516 - $74,020	$74,021 +

How did you hear about Clarity?:

Referral(Friend/Family) Referral(Physician) Newspaper Magazine Social Media

Billboard Health Fair Other(Specify)

Insurance and Patient Responsibility

Insurance claims are submitted on your behalf by Clarity Healthcare. Deductibles and co-pays are due at the time of check-in.

You are responsible for knowing what your insurance does and does not pay and if our providers are in-network or not in-network with your insurance plan. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.

You will need to update or verify personal information at each visit and show your current insurance card.

Your insurance card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your benefits, you will be considered a self-pay patient. As a self-pay patient, a minimum $50 fee is expected to be paid in full at the time of service.

If you can provide your insurance card and the insurance pays your claim in full, you will be reimbursed.

If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be rescheduled.

The above information is true to the best of my knowledge. I authorize assignment of benefits for services received to be paid directly to Preferred Family Healthcare dba Clarity Healthcare. I understand that I am financially responsible for any balance. I also authorize Preferred Family Healthcare dba Clarity Healthcare or my insurance company to release any information required to process my claims.

Patient/Guardian Signature _____ Date _____