Daily Planet HEALTH+SERVICES

PEDIATRIC REGISTRATION FORM

Patient Account #: _____

Date: _____

PATIENT INFORMATION

Last Name:	**First Name:**	**Middle Initial:**
Date of Birth: *MM/DD/YYYY*	**Preferred Name:**	**SSN:**
Address:		
City:	**State:**	**Zip:**
Primary Phone #: *Type:* □ Cell □ Home □ Work		**Secondary Phone #:** *Type:* □ Cell □ Home □ Work
Email address:		
Sex: □ Male □ Female □ Choose not to disclose		**Are you a student?** □ Yes □ No
Primary Language: □ English □ Spanish □ Dari □ Pashto □ Other _____		
Race(s) - Check All that Apply: □ American Indian/Alaska Native □ Asian□ Asian Indian □ Black/African American □ Chinese □ Filipino □ Guamanian or Chamorro □ Japanese □ Korean □ Native Hawaiian □ Other Pacific Islander □ Samoan □ Vietnamese □ White □ Other_____		
Ethnicity: □ Hispanic or Latino □ Chicano □Cuban □ Mexican □Mexican - American □ Spaniard □ Puerto Rican □ non-Hispanic		

PARENT/GUARDIAN

Last Name:	**First Name:**		**Middle Initial:**
Date of Birth: *MM/DD/YYYY*	**SSN:**		
Primary Phone #: *Type:* □ Cell □ Home □ Work	**Secondary Phone #:** *Type:* □ Cell □ Home □ Work		
Email:	**Sex**: □ Male □ Female □ Choose not to disclose		
Address:	**City**:	**State:**	**Zip:**
Primary Language: □ English □ Spanish □ Dari □ Pashto □ Other _____	**Employer Name:**		
Parent Employment Type: □ Full-time □ Part-time □ Self Employed □ Disabled □ Retired □ Unemployed □ Dependent			
Relationship to Patient:			

EMERGENCY CONTACT

Name:	**Relationship**:
Phone #:	**Address:**

What is your family's current living situation?

□ Own home (self or family)
□ Rent home or apartment -- not income based (self or family)
□ Rent- Housing Choice Voucher (Section 8)

□ Rent- Income-based (**not** Housing Choice Voucher/Section 8; **no** supportive or case management services)
□ Rent- Public Housing complex

□ Permanent Supportive Housing (low-income housing **with** supportive or case management services)
□ Other housing programs designed to help people experiencing homelessness (e.g., rapid rehousing programs)
□ Live temporarily with family/friends (due to safety concerns, economic reasons, or risk of homelessness)
□ Transitional housing program (e.g., Veteran's transitional, Recovery house, Healing Place Community, re-entry housing, etc.)
□ Shelter (homeless shelter, family shelter)
□ Street (outdoors, makeshift shelter, encampment, car)
□ Other (please specify):_____

Please let us know who referred you to us: _____

Patient Account #: _____

PEDIATRIC REGISTRATION FORM

Date: _____

I authorize DPHS to send and receive my health information electronically through an interoperability platform.

Name	Relationship	Contact number

INSURANCE INFORMATION (PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Do you have health insurance? □ No □ Yes	**Select all that apply:** □ Medicaid □ Medicare □ Private □Other
Relationship to policy holder: □ Self □ Spouse □ Child □ Other_____	**Do you have a primary care physician?** □ No □ Yes (If yes) Name: _____
Insurance card number (if unable to present card):	
Insurance Company:	**Group:**

INCOME INFORMATION

Include all sources of income, including but not limited to, employment, unemployment benefits, SSI/SSDI, Veterans Benefits, Pension, Retirement, TANF, Child Support, Alimony

SLIDING FEE DISCOUNT PROGRAM

DPHS offers a Sliding Fee Discount for patients living at or below 200% of the poverty level. See the Sliding Fee Discount Program Eligibility Notice and Requirements for more information.

- Eligibility is based on income and family/household size only. A **family/household** is a group of two or more people related by marriage (including civil unions or intentional co-habitation,) birth, or adoption (all such persons considered dependents of adult); all such related persons are considered as members of one family/household. For example, all those included on tax returns would be considered members of a single family.
- Proof of income is required to determine eligibility. You have 30 days to provide this documentation. You will be responsible for the full fee if proof of income is not provided. Please complete the following if you wish to apply for the Sliding Fee Discount Program.

Total Family/Household Income: **$_____** □ Annually □ Monthly □ Bi-Weekly □ Weekly

Total Number of people in family/household (including yourself) **_____**

***Note**- Providing this information, even if you choose not to apply for the sliding fee discount program, helps us maintain grant funding so that we can continue to provide quality health care to the community.*

Name (including self)	Source of Income	Amount	Frequency (annually, monthly, etc.)	Relationship

****Please note: Daily Planet Behavioral Health Clinic **does not provide one-time only** mental health evaluations for court, disability benefits, or other purposes. If you need this service only, we can refer you to another agency that can do it for you. Daily Planet Health Behavioral Health Clinic **does not provide** services for individuals **under 18 years old.** ****

I hereby certify that all the information provided on this form is true. I understand that this application will be reviewed each visit and that proof of income to qualify for the SFDP is required annually, and as income changes. I further understand that, if applicable, I must provide proof of homelessness.

_____ _____ _____

Parent Signature Printed Name Date

Patient Name: _____

Date of Birth: _____

Daily Planet Health Services

Consent for Treatment, Notice of Privacy Practices Acknowledgement and Financial Responsibility Agreement

Thank you for choosing Daily Planet Health Services (DPHS) as your Health Home. We are committed to providing you high quality of care and service. Please read the information below and sign this form before receiving any DPHS services.

Consent for Treatment

- I authorize medical treatment by the provider, clinical staff and technical employees assigned to my care.
- I authorize my providers to order any ancillary services, such as lab or radiology tests, or any other services or treatments deemed necessary for my care and safety.
- I understand I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns before treatment is provided.
- In the event that a healthcare worker is exposed to my blood or body fluid in a way which may transmit HIV, Hepatitis B virus, or Hepatitis C virus, I consent to the testing of my blood and/or body fluids for these infections and the reporting of my test results to the health care worker who has been exposed, as required by Virginia law.
- I understand that Daily Planet Health Services uses an electronic prescribing mechanism for electronic transmission of prescriptions and that any medications my provider prescribes for me may be communicated electronically through any local or mail order pharmacy I have designated.
- I understand that Daily Planet Health Services' providers may access prescription information contained in the Virginia Prescription Monitoring program.
- I authorize the release of my prescription history to my Daily Planet Health Services provider from any pharmacy or drug monitoring agency.
- I understand that there are additional consent forms for behavioral health and dental services when registering for those services.

Acknowledgement of HIPAA Notice of Privacy Practices

Our Notice of Privacy Practices (NPP) explains how we may use and disclose health care and billing information about you. As provided in our Notice of Privacy Practices the terms of our notice may change. If we change our notice, you may obtain a revised copy at our website at: www.dailyplanetva.org.

- I have been given an opportunity to read the Notice of Privacy Practices and a copy is available at my request.
- I understand that I may ask questions if I do not understand any information contained in the NPP.
- With my consent, Daily Planet Health Services may:
  - Call my home or other designated location, text or other electronic communication given on the registration forms and leave a detailed message in reference to ***appointment reminders, insurance, or billing items.***
  - Call my home or other designated location, text or other electronic communication, given on the registration forms, and leave a detailed message in reference to my ***clinical care, including laboratory results or medications.***

Patient Name: _____

Date of Birth: _____

I understand that I have the option to authorize Daily Planet Health Services to speak to family members or other individuals about results, findings, and care decisions. I authorize Daily Planet Health Services to communicate with the individuals listed below. I understand that I may revoke or modify this authorization at any time by submitting a written request.

Name	Relationship	Contact Number

Financial Responsibility

I accept that I am financially responsible for all services rendered on my behalf for which a charge may be associated. I accept personal responsibility for the payment of fees, co-pays, co-insurance, deductibles and all other procedures or treatments not covered by my insurance plan. I acknowledge that it is my responsibility to provide DPHS with current insurance information. I authorize DPHS to verify my insurance and submit claims to my insurance carrier. I understand not all services provided at DPHS may be covered by my insurance plan. In the event my insurance plan is not valid or coverage is not active at the time services are rendered, or my provider is not listed as a participating provider by my insurance plan, I will be solely responsible for the amount for the services rendered. I agree to inform the office of any changes in my insurance coverage.

I understand that if my income is below 200% of the Federal Poverty Guidelines, I am eligible to apply to DPHS' Sliding Fee Discount Program, reducing my financial responsibility based on my family size and income. This discount can apply to insurance co-pays, co-insurance and deductibles, as well as self-payments. To qualify, I must provide proof of income. This must be provided within 30 days after registration. After 30 days, with no proof of income, I may be responsible to pay the full cost of service. I agree to notify DPHS of any changes to my income or family status at the time of services.

I understand whether I have insurance or self-pay, I am financially responsible for any costs associated with collection of patient balances. I acknowledge DPHS accepts payment by cash, debt or credit card, check or money order.

Patient Rights and Responsibilities

It is the policy of the Daily Planet Health Services (DPHS) to support and protect the fundamental human, civil, constitutional, and statutory rights of each person receiving its health care services. Furthermore, each patient shall be informed of his/her rights in the language that the client understands. You may request a printed copy at any time or obtain a revised copy at our website at: www.dailyplanetva.org.

By signing below, I acknowledge that I have read, understand, and agree to the above items.

_____ _____ _____

Signature of Patient or Authorized Representative | Printed Name | Date

Sliding Fee Discount Program
Eligibility Notice and Requirements

Daily Planet Health Services' mission is to provide accessible quality health services regardless of your ability to pay. A Sliding Fee Discount Schedule is used to determine the fee schedule for services. This Schedule based on the federal poverty income guidelines and is determined by family/household and annual income.

Please bring in within 30 days current copies of one of the following documents as proof of income:

-Current employment paycheck stub--one month
-Copy of all recent year W-2/ or most recent tax return
-Virginia Employment Commission (VEC) record (most recent 3-month period)
-Proof of Public Assistance (e.g., TANF, Food Stamps) NOTICE OF ACTION
-Proof of SSI, SSDI, and/or Social Security payments (e.g., award letter)
-Pension or Retirement income statement
-Copy of unemployment compensation payment
-Copy of Veteran's Benefits determination letter/ income statement
-Copy of child support award/ proof of payment
-Copy of Alimony award/ proof of payment
-Current bank statement with direct deposit information
-Employer Report Letter-Income Statement on employer letterhead

Homelessness documentation from homeless service agency or outreach worker- On agency letterhead, dated within 30 days of appointment.
If homeless and no income, documentation verified by an agency case manager or outreach worker.
If you are unable to pay the required service fees these charges will be billed to your account.

At the time documentation is provided any eligible discount will be applied to previous services retroactively up to 30 days. After 30 days, with no proof of income, you may be responsible to pay the full cost of service—if you do not have this payment, you may be rescheduled (not seen that day) and asked to bring documentation and payment at the next visit. We appreciate your notifying Daily Planet Health Services of any change in income or dependents at the time of services.

I understand Daily Planet Health Services' proof of income and fee payment policy and agree to provide the required proof of income information within 30 days of the date shown below in order to qualify for discounted fees for services.

Patient Name (printed) _____ Patient Signature _____

Date: _____

Legal Representative (printed, if required): _____

Legal Representative Signature: _____

Patient Rights and Responsibilities

It is the policy of the Daily Planet Health Services (DPHS) to support and protect the fundamental human, civil, constitutional, and statutory rights of each person receiving its health care services. DPHS complies with all applicable federal civil rights laws, including Section 1557 of the Affordable Care Act. DPHS does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language,) age, disability, or sex. Furthermore, each patient shall be informed of his/her rights in the language that the client understands and will receive a written copy of the *Patient Rights & Responsibilities*.

Fundamental Rights of Patient

To be treated with dignity and respect, and with the utmost of professional care, without regard to race, color, religion, national origin, sex, sexual orientation, source of payment, age, socioeconomic status, or disability.

Treatment Rights

1. To receive care and treatment from qualified and competent staff.
2. To participate in the development and revision of individual treatment or service plan.
3. To be given the reasons for any proposed change in professional staff responsible for services or treatment.
4. To be free from experimental research procedures.
5. To refuse or terminate treatment and to be informed of the consequences of these actions.
6. To be informed about diagnoses, services, treatment, and prognosis in terms that can be understood.
7. To participate in formulating discharge and follow-up care plans.

Confidentiality Rights

To expect that all communications and records that pertain to patient services and treatment will be treated as confidential under state and federal law and that they are not released to anyone unless:

1. The patient consents in writing
2. The disclosure is permitted or required by law.
3. Patient presents as a danger to self or others.
4. Child or elder abuse or neglect is suspected and is reported under state law.

Communication Rights

1. Language assistance services for individuals with limited English proficiency including qualified interpreters and electronic and written translated documents.
2. Auxiliary aids and services for individuals with disabilities, including qualified American Sign Language interpreters, Video Remote Interpretation, and information in alternate formats (such as large print and accessible electronic formats).

Other Rights

1. To initiate a complaint or grievance against DPHS or its staff.
2. To be informed of fees for which the client is responsible and the basis for the fees.
3. To be provided with reasonable accommodation for qualified individuals with disabilities

Patient Responsibilities

Every patient has a responsibility to:

1. Treat staff and other consumers of DPHS with respect and consideration.
2. Keep all appointments. Arrive 15 minutes early to allow us to provide you with the best care possible.
3. Make every attempt to notify staff 24 hours prior to appointment time if you are unable to keep an appointment.
4. To participate in the development of a treatment or service plan with provider or treatment team.
5. To inform staff of any intention not to follow treatment or service plan, or of decision to discontinue services at DPHS.
6. To report any grievances or complaints, following the procedures provided at registration, or provided upon request.

There are very clear guidelines within DPHS' Guidelines and Expectations that address violence, alcohol and drug use and the possession of weapons.

1. Violence or the threat of violence will not be tolerated, even in the act of self-defense.
2. Alcohol and/or illicit drug use is not allowed. If we suspect that you are under the influence of alcohol or drugs, you may be asked to leave the agency.
3. The possession of weapons of any kind is not permitted. No weapons or potential weapons are allowed on the property.

_____ _____ _____

Signature **Printed Name** **Date**

January 2025