MRN#: _____

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name:	**First Name:**	**Middle Initial:**
Date of Birth: *MONTH/DAY/YEAR*	**Preferred Name:**	
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	

EMERGENCY CONTACT

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

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 policyholder: □ 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:** _____

ADDITIONAL INFORMATION

Marital status: □ Single □ Married □ Partner □ Divorced □ Legally Separated □ Widow

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

What is your 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): _____

Patient Employment Type: □ Full-time □ Part-time □ Self Employed □ Disabled □ Retired □ Unemployed □ Dependent

Patient Employer Name: _____ **Are you a student?** □ Yes □ No

Are you a US veteran? □ Yes □ No **Are you a Farmworker?** □ Yes □ No

Please let us know who referred you to us: _____

I hereby certify that all the information provided on this form is true.

_____ _____ _____

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

****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. ****

Consent for Treatment and Notice of Privacy Practices Acknowledgement

Daily Planet Health Services (DPHS) is committed to delivering high-quality, patient-centered care. In accordance with healthcare regulations and to ensure that you are fully informed, we ask that you review and sign this form prior to receiving services. This document provides important information about your rights and responsibilities regarding medical treatment and how your health information may be used and shared. Please read carefully and speak with a staff member if you have any questions before signing.

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 consent to have records shared through the Health Information Exchange. This means your providers and care team can securely share your health information with other providers to help coordinate your care. Notify a Daily Planet staff member if you choose to stop sharing your information.
- 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 about ***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.***

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

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

_____ _____

Name of Patient **Date of Birth**

_____ _____

Signature of Patient or Authorized Representative **Signature Date**

Rev. 12/2025

Patient Rights and Responsibilities

It is the policy of 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, and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex. Each patient shall be informed of their rights in the language that the client understands, and can receive a written copy of the Patient Rights & Responsibilities upon request. You may request a printed copy at any time or obtain a revised copy at our website: www.dailyplanetva.org.

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, 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**

Sliding Fee Discount Program Eligibility Notice, Requirements and Financial Responsibility Acknowledgement

Mission & Program Information

Daily Planet Health Services (DPHS) provides accessible, quality health services regardless of ability to pay. A Sliding Fee Discount Schedule, based on Federal Poverty Guidelines, is used to determine fees for patients living at or below 200% of the poverty level. **Eligibility is determined by family/household size and annual income**.

- A family/household is defined as a group of two or more people related by marriage (including civil unions or intentional cohabitation), birth, or adoption (all such persons considered dependents of the adult). For example, all those included on tax returns are considered members of one family/household.

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, which may reduce my financial responsibility based on my family size and income. This discount can apply to insurance co-pays, co-insurance, deductibles, and self-pay balances. To qualify, I must provide proof of income for one month **within 30 days of registration**. If proof of income is not received within this timeframe, I may be responsible for the full cost of services. I agree to notify DPHS of any changes to my income or family status at the time of services.
- I understand that whether I have insurance or am self-pay, I am financially responsible for any costs associated with my patient balance, including collection costs. I acknowledge that DPHS accepts payment by cash, debit or credit card, check, or money order.
- If I am unable to pay the required service fees at the time of service, charges will be billed to my account. **Consistent with the 30-day income documentation requirement**, failure to provide proof of income may result in full charges being applied. If payment is not available, I may be rescheduled and asked to bring documentation and payment to a future visit. When documentation is received, any eligible discount will be applied retroactively to services rendered within the prior 30 days. I understand the importance of notifying Daily Planet Health Services of any changes 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. 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 hereby certify that all the information provided on this form is true.

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

SFDP Application and Temporary Income Certification

Proof of Income Requirements: Please bring in current copies of one of the following documents within 30 days as proof of income (check what applies):

I can provide documentation of income:	**I cannot provide documentation of income:**
☐ Current employment paycheck stub – one month ☐ Copy of recent 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	**If you are experiencing homelessness:** If applicable, you must provide proof of homelessness. ☐ Homelessness documentation from a homeless service agency or outreach worker – must be on agency letterhead, dated within 30 days of appointment. ☐ If homeless and no income, documentation verified by an agency case manager or outreach worker is required. **I cannot provide proof of my income, and I need temporary eligibility:** ☐ I get paid in cash. ☐ I do not get paychecks. ☐ I do not get pay stubs. ☐ I cannot get a letter from my employer (explain): _____ _____
Total Family/Household Income: **$ _____** □ Annually □ Monthly □ Bi-Weekly □ Weekly **Total Number of people in family/household** (including yourself) **_____**	
☐ **I do not wish to apply for the sliding fee discount. I understand that I will be charged the full cost of services and will be ineligible for 340B Pharmacy discounts and other benefits.**	

I certify that I have no other way to document my income at the time of service and that all information above is true and correct. I understand this is temporary eligibility and will be expected to renew monthly. I understand this will be used to determine SFDP eligibility and may be verified by DPHS. If I intentionally misrepresent my income, I may have to repay benefits received and may be prosecuted under State law.

_____ _____ _____

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

DPHS Staff Certification:

I certify that I asked the applicant/recipient about all household income. The information was provided solely by the applicant and reflects their self-report. I did not alter this information. I understand falsification or assisting in falsification may result in termination and legal action.

_____ _____ _____

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