Fetter Health Care
NETWORK

51 Nassau Street
Charleston, SC 29403
Phone (843) 722-4112
Fax (866) 285-7156

PATIENT DEMOGRAPHICS

Last Name: ______ First Name: ______ Middle: ______
Social Security Number: ____-____-____ Date of Birth: ______ Sex: □ Female □ Male
Home Address: ______ City ______ State ______ Zip: ______
Mailing Address: ______ City: ______ State ______ Zip: ______
Home Phone ______ **Work Phone** ______ **Cell Phone:** ______ Email: ______
Emergency Contact: ______ **Relationship:** ______ Phone: ______

Marital Status: □ SINGLE □ MARRIED □ DIVORCED □ SEPARATED □ WIDOW(ER)
Race □ WHITE □ Black □ ASIAN □ Native Hawaiian □ PACIFIC □ Other □ AMERICAN INDIAN OR ALASKA NATIVE
Ethnicity: □ LATINO □ HISPANIC □ OTHER
Veteran: □ YES □ NO

Gender Identity □ Male □ Female □ Female to Male □ Male to Female □ Gender Queer □ Other □ Declined
Sexual Orientation □ Lesbian, Gay or Bi-sexual □ Straight or Heterosexual □ Bisexual □ Something Else □ Don't Know □ Declined

LIVING/MIGRANT STATUS

Living Status: □ RENT □ OWN □ TEMPORARY If Temporary □ SHELTER □ FAMILY OR FRIENDS □ ASSISTANT LIVING

Migrant Status

	Yes	**No**
Have any member(s) of your family worked in agriculture (i.e. field, packing shed?	□ Seasonal Migrant	□ Ineligible
Are you a resident of the County in which you live?	□ Seasonal	□ Migrant
Are you planning to stay and live in that County?	□ Seasonal	□ Migrant
Did you come to this area to do farm work?	□ Migrant	□ Ineligible
Will you leave this area to follow farm work?	□ Migrant	□ Ineligible

Local Camp/Residence Crew Leader/Growers

What is your household size? ______ **# of children** ______ **# of Adults** ______

What is your household income? ______ **weekly** ______ **monthly** ______ **yearly** ______

PARENT/GUARDIAN'S INFORMATION (RESPONSIBLE PARTY)

Last Name: ______ **First Name:** **Middle:**
Social Security Number: ____-____-____ **Date of Birth:** **Sex:** □ Female □ Male
Home Address: ______ **City** **State** **Zip:**
Home Phone: ______ **Work Phone** ______ **Cell Phone:** ______ **Relationship:** ______

INSURANCE INFORMATION

Company Name ______

Policy Number: ______ **Group Number:** ______ **Co-Pay:** $ ______

2nd Company Name: ______

Policy Number ______ **Group Number:** ______ **Co-Pay:** $ ______

□ **SLIDING FEE APPLICATION ATTACHED**

I, the undersigned certify that the information on this Enrollment Form is given to the best of my knowledge. I understand I am responsible for presenting my Insurance Card at each visit and I am financially responsible for services not paid by my Insurance Company. I further understand that any Nominal Fee, Sliding Fee, or Co-Payment required be paid on the dates services are rendered. I authorize Fetter Health Care Network to release any medial information that may be needed for billing, consultation, or referral purposes for my dependent(s) or me. Fetter Health Care Network reserves the right to verify Medicaid/Medicare insurance coverage for all patients and apply charges appropriately.

□ **Privacy Notice Issued**

Patient (Parent/Guardian) Name: ______ **Date:** ______
Medical Services Staff: ______ **Date:** ______

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Sliding Fee Discount Program Acknowledgment Form

Fetter Health Care Network must have a Sliding Fee Discount Program (SFDP) which ensures that patients have use of all services in the health center, regardless of their ability to pay. Specifically, the sliding fee discount program must include the following:

(1) A listing of fees for services;

(2) A corresponding list of discounts for eligible patients that is adjusted based on the patient's ability to pay; and

(3) Board-approved policy and procedures, including those around billing and collections.

While the sliding fee discount program supports that patients can be monetarily invested in their care based on their ability to pay, it is intended to decrease financial burden to care for patients at or below 200 percent of the Federal Poverty Guidelines (FPG). Therefore, neither the fees themselves nor the supporting operating procedures for assessing patient eligibility and collecting payment should not care.

Please Initial:

________ **I understand the Sliding Fee Discount Program and agree to complete the Sliding Fee application.**

________ **I understand the Sliding Fee Discount Program and refuse to complete the Sliding Fee application.**

I understand my refusal to complete the Sliding Fee Scale Application means that you cannot be assessed for discount programs. Therefore you will be required to pay 100% for services provided by Fetter Health Care Network after any insurance payment and adjustment.

______________________________ ______________
Patients' Name (Please Print) Date

____
Patient's Signature

______________________________ ______________
FHCN Employee's Signature Date

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SLIDING FEE APPLICATION

It is the policy of Fetter Health Care Network to provide services regardless of an individual's inability to pay. Discounts are offered depending upon household income and family size. A **"family"** is one or more persons living in one dwelling place who are related by blood, marriage, or law. Adults and minor children are considered a family. **Relatives over 18 (that are not full time students) are not eligible to be used as dependents for this application process.** Please complete the following questions to determine if you or your family members are eligible for our sliding scale program.

Household Member's Name	**Date of Birth**	**Weekly**	**Monthly**	**Annual**	Date All Documentation Received	Documentation Received by
You:						
Spouse:						
Dependent:		X	X	X		
Dependent:		X	X	X		
Dependent:		X	X	X		
Dependent:		X	X	X		

The total number of family members living in your household (working and non-working):_______

Qualified Poverty Percentage	Medical Slide Category	Dental Slide Category	Slide Effective Date	Slide Termination Date

Note: Include income from all sources from Adults listed above. These include, but are not limited to: gross wages, tips, social security, disability, pensions, annuities, veterans' payments, net business or self-employment, alimony, child support, military, unemployment public aid and any other form of income.

All Information Will Be Kept Confidential

I certify that the above information is true and correct to the best of my knowledge. I am also aware that this information may be randomly audited at any time for verification purposes. Knowingly providing false information may result in termination of Sliding Fee Discount Program and/or termination of services at Fetter Health Care Network.

_______________________________ _______________
Signature of Applicant/Printed Name Date

_______________________________ _______________
Signature/Printed Name of Financial Eligibility Specialist Date of Interview

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Sliding Fee Discount Plan Benefit

✓ Reduced fees for uninsured, underinsured, high deductible plan and insured.

✓ Discounted fees for Medical, Dental and Pharmacy

Requirements:

Provide verification of family size and income

Selection A: Income
(Choose 1)

1. Current pay stub
2. Prior Year tax return
3. Unemployment check
4. Alimony check, court decree
5. Notarized statement

Selection B: Family Size Income
(Choose 1)

1. Picture ID card
2. Court ordered settlement
3. Tax return
4. Social security card for family members
5. Birth Certificates

✓ Services will not be denied for inability to pay.

✓ Services will not be denied for any reason including: race, color, sex, national origin, disability, religion, sex orientation or gender identity

Payment Accepted:

Cash, Debit & Credit, Checks & Insurance

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CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Full Name (print): ______________________________ **Date of Birth:** ____/_____/_____

Last 4 of SS#: ______________

Fetter Health Care Network, Inc. is hereby authorized to release or receive confidential information to/from the following agency or individual (please list to include name, phone #, fax # and address of agency, family member or individual below):

Name______________________________Relationship_______________Phone/Fax Number: __________

Name______________________________Relationship_______________Phone/Fax Number: __________

Name______________________________Relationship_______________Phone/Fax Number: __________

Information may be received and given in the following form (please check all that are allowed):

☐ Written Documentation	☐ Audio	☐ Video
☐ Electronic	☐ Verbal	☐ Other

Initial	Expiration Date	Permission to Release the Following:
		I hereby waive any psychiatrist-patient and/or psychologist-patient privilege with respect to information released to the above-named individual or agency.
		I hereby waive any privileges concerning records of infectious or contagious disease, including TB, STD, HIV/AIDS confidential information with respect to records released to the above name individual or agency.
		I hereby waive any privileges concerning records of drug or alcohol abuse and/or treatment or mental health treatment with respect to records released to the above name individual or agency.
		I hereby consent to the release of information for case management services related to discharge planning and social services benefits.
		I hereby consent to the release of all healthcare information for primary care services related to diagnosis, treatment, evaluation, and follow-up.
		I hereby consent to the release of healthcare information ONLY related to the following diagnosis. Please specify diagnosis or state not applicable.______________________________
		I hereby consent to accepted detailed appointment reminders via phone, email or text messaging using the information filed with the health center.

I hereby release Fetter Health Care Network, its officers, agents and employees from any and all liabilities, damages and claims which might arise from the release of information authorized above. I understand that signing this form is voluntary and that if I do not sign, it will not affect the quality of my treatment at FHCN. If I change my mind, I understand that I can withdraw this authorization by providing a written notice of withdrawal. The withdrawal will be effective immediately upon my health care provider's receipt of my written notice, except that the withdrawal will not have any effect on any action taken by my health care provider in reliance on this authorization before it received my written notice of withdrawal.

I acknowledge that this consent for release of protected health information is valid one year from the signing date unless otherwise stated above.

______________________________________ ____________________
Signature of Patient or Patient's Representative Date

______________________________________ ____________________
Witness Signature Date

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General Consent for Care and Treatment Consent

I, ____, or the Parent or Legal Guardian(s) of: ____, a registering patient of Fetter Health Care Network, hereby give my consent to be provided medical treatment as necessary.

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

You voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought you to seek care at this practice. You understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

You further understand that medical information may be shared on an as needed basis with other referred medical sources and that any medically necessary procedure may be performed if it is in the best interest of the health of the patient as deemed necessary by the medical staff of Fetter Health Care Network.

AUTHORIZATION AND CONSENT

I certify that I have read and fully understand the above statements and consent fully and voluntarily to the contents of those statements. I further provide my authorization for the performance of the evaluation, treatment and procedures described in the statements.

______________________________________ ______________________________
Signature of Patient or Personal Representative Date

____
Printed Name of Patient or Personal Representative

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Fetter Health Care Network makes available copies of the following documents at

www.FetterHealthCare.org/patient-registration

A. **SCHIEx Information Exchange** which shares personal health information to provide, coordinate, or manage your health care and any related services.

B. **Notice of Patients** (FTCA) which explains health centers are considered Federal employees and are immune from lawsuits, with the Federal government acting as their primary insurer.

C. **Patient Access & Hours of Operation** which outlines the accessibility of sites and services for all health center locations

Patient Certification Policy Form which explains expectation of payment and information needed.

D. **Consumer Rights** and **Patient-Centered Medical Home Acknowledgement Form** which outlines my rights as a patient at Fetter Healthcare Network.

E. **General Consent for Care and Treatment** which allows the health center providers to perform evaluations, treatment, and procedures.

F. **Notice of Privacy Practices** which details how my personal health information including substance abuse, mental health and medical services may be used and disclosed as permitted under federal and state law. I have read, or have had read to me, the notice and understand the contents of this notice.

G. **Informed Consent for Counseling Services** which explains counseling services and policies.

H. **Limits to Confidentiality** which outlines my rights to confidentiality as a consumer at Fetter Healthcare Network, Inc.

I. **Consent of Release of Information** which outlines my rights to confidentiality as a consumer at Fetter Healthcare Network, Inc.

I acknowledge that I have online access to these documents listed above and commit to reviewing.

Signature of Patient or Patient's Representative: ______________________________ Date: ______________

If not signed by the patient, please indicate the relationship of the person signing to the patient:

Relationship: ______________________________