Fetter Health Care
NETWORK

Corporate Office:
51 Nassau Street
Charleston, SC, 29403
Phone:(843) 722-4112
Fax: (843) 722-5726

ANNUAL PATIENT REGISTRATION FORM

PERSONAL INFORMATION

Last Name: First Name: Middle Name:

Address: City: State: Zip:

Date of Birth: Social Security:

Home Phone: Cell Phone: Other:

Email:

Emergency Contact: Phone: Relationship:

Preferred Pharmacy:

Street Address: City: State: Zip:

HELP US GET TO KNOW YOU BETTER

Gender at birth: ☐ Male ☐ Female Preferred Pronoun: _____

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male (Female to Male) ☐ Transgender Female (Male to Female) ☐ Gender Queer ☐ Other ☐ Prefer Not to Say

Sexual Orientation ☐ Lesbian/Gay Homosexual ☐ Straight Heterosexual ☐ Bisexual ☐ Prefer Not to Say ☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (Check All ☐ Black/African American ☐ White ☐ American Indian/Alaskan Native ☐ Native Hawaiian ☐ Chinese ☐ Other Pacific Islander ☐ Korean ☐ Guamanian or Chamorro ☐ Asian Indian ☐ Filipino ☐ Japanese ☐ Vietnamese ☐ Samoan ☐ More than one race ☐ Other (Name race(s): _____

Preferred Language ☐ English ☐ Spanish Other _____ Translator needed Yes No

Are you Homeless? ☐ Yes ☐ No If yes, you are ☐ Doubling up ☐ Shelter ☐ Street ☐ Transitional Housing ☐ Other

Are you a Veteran? ☐ Yes ☐ No

Are you an Agricultural? ☐ Yes ☐ No If yes, you are ☐ Migrant ☐ Seasonal Worker

FAMILY SERVICES

Please help us extend our services to those in need by providing information about you and your family below:

Family Size: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 or more

Household Income Level: $

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SCHIEx (South Carolina Health Information Exchange)

Enables physicians across SC to view the patient information they need to make well-informed decisions. By providing real-time access to life-saving data, SCHIEx is improving the quality, safety, and efficiency of healthcare delivery in our state.

SCHIEx Consent: ☐ **Yes** ☐ **No** **If no, state reason:** _____

PATIENT-PROVIDER COMMUNICATION ACCESS

I understand and agree but I may be contacted by: Required to select two (2).

YES	NO	Patient Portal		YES	NO	Telephone		YES	NO	Text		YES	NO	Emergency Contact
YES	NO	Postal Service		YES	NO	Voicemail		YES	NO	Email				

RESPONSIBLE PARTY INFORMATION (Any patient under 18 must have a responsible party)

☐ **Patient (18 years or older)** ☐ **Custodial Parent** ☐ **Guardian** (proof of legal status required for treatment

Last Name: _____ **First Name:** _____ **Middle Name:** _____

Date of Birth: _____ **Social Security:** _____

Home Phone: _____ **Cell Phone:** _____ **Other:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

MEDICAL INSURANCE (Medicaid and/or Medicare)

□ I currently have MEDICAL insurance (see below)
□ I currently DO NOT have MEDICAL insurance.
□ I would like to apply for the SLIDING-FEE SCALE
Medical Insurance Name: _____

Policy/ID Number: _____
□ I currently have secondary MEDICAL insurance (see below)
Medical Insurance Name: _____

Policy/ID Number: _____

DENTAL INSURANCE

□ I currently have DENTAL insurance (see below)
□ I currently DO NOT have DENTAL insurance.
□ I would like to apply for the SLIDING-FEE SCALE
Dental Insurance Name: _____

Policy/ID Number: _____
□ I currently have secondary DENTAL insurance (see below)
Dental Insurance Name: _____

Policy/ID Number: _____

PRESCRIPTION INSURANCE

□ I currently have PRESCRIPTION insurance (see below)
□ I currently DO NOT have PRESCRIPTION insurance.
□ I would like to apply for the SLIDING-FEE SCALE
Medical Insurance Name: _____

Policy/ID Number: _____
□ I currently have secondary PRESCRIPTION insurance (see below)
Medical Insurance Name: _____

Policy/ID Number: _____

ADDITIONAL INSURANCE

□ I currently have ADDITIONAL insurance (see below)
□ I currently DO NOT have ADDITIONAL INSURANCE
Medical Insurance Name: _____

Policy/ID Number: _____

Name of Patient (Parent or Guardian): _____ Date _____

Signature of Patient (Parent or Guardian): _____ Date _____

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ANNUAL PATIENT REGISTRATION FORM

Consent for Release and Consent to Treatment Health Information
for Treatment, Payment, and Health Care Operations

In order to protect your privacy, we ask that you complete this form so we know the ways in which we may communicate with you regarding your health information. Please mark as many of the communication options below as you feel comfortable with, so we have multiple ways to reach you regarding important matters concerning your health care.

Patient Full Name (print): _____ **Date of Birth:** ____/_____/_____
Last 4 of SS#_____

I prefer to receive my appointment reminders and information in the following method:
□ **Text message** □ **Phone call** □ **Patient Portal** □ **Email** □ **Documentation**

I authorize Fetter Health Care Networks to discuss my healthcare as indicated with the following individuals:

Name:			Name:			Name:		
Name:			Name:			Name:		
Relationship:			Relationship:			Relationship:		
Phone:			Phone:			Phone:		
Yes	No	Appointment Reminders	Yes	No	Appointment Reminders	Yes	No	Appointment Reminders
Yes	No	Test Results	Yes	No	Test Results	Yes	No	Test Results
Yes	No	Billing Information	Yes	No	Billing Information	Yes	No	Billing Information
Yes	No	Room with Doctor	Yes	No	Room with Doctor	Yes	No	Room with Doctor

If applicable, minor children's immunization records and/or school excuses may be released as needed to the following schools and daycares if applicable:

_____

_____
Name Phone

_____
Name Phone

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 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

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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 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 the release of protected health information is **valid one year** from the signing date unless otherwise stated above.

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 consent to continue care 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.

Fetter Health Care Networks conducts periodic patient satisfaction surveys. Survey respondents are chosen at random. If you are chosen to receive the survey, you will receive a text message to share your opinion regarding your recent experience at our health center. Please note text message rates may apply.

Yes No	I would like to participate in Fetter Health Care Networks Patient Satisfaction Survey. I consent to receive text messages regarding my recent experience.

Fetter works to keep its patients informed about new services, locations, and providers.

Yes No	I would like to receive updates via email on record.

I understand that I have the right to change or cancel this request at any time by notifying the Privacy Officer, in writing, at Fetter Health Care Network, Attention: Quality Department, 51 Nassau St. Charleston SC 29403. I also understand that the changes or cancellations will not affect the action taken based on this request prior to the change or cancellation.

_____	_____
Patient Name (Printed)	Date
_____	_____
Signature of Patient or Legal Guardian	Date
_____	_____
FHCN's Employee Print	Date
_____	_____
FHCN's Employee Signature	Date

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RECEIPT OF INFORMATION

I understand that I can request a copy or access the below information.

Agency Forms	
□ Patient Services Orientation	□ Informed Consent for Counseling Services
□ Additional Services	□ Cancellation, No-Show Policy & Refusal to Pay Policy
□ Appropriate Patient Conduct	□ Consumer Rights
□ Consumer Rights/ Grievances and Satisfaction Surveys	□ Patient Rights and Responsibility
□ Code of Ethics Statement	□ Patient-Provider Communication Access
□ Notice of Privacy Practices	□ Good Faith Estimate
□ Limits to Confidentiality	□ Consent for Release and Treatment

I understand that I can request or retrieve a copy of the above document by:

- □ Requesting from the Front Desk
- □ Reviewing on Patient Portal
- □ Reviewing the forms on Agency Websites.

I acknowledge the above information:

Print Name of Patient: _____

Patient/Legal Guardian Signature: _____ Date: _____