MONROE CITY SCHOOL DISTRICT

and

Clarity Healthcare/Preferred Family Healthcare, Inc.

Telehealth Patient Registration
(Please Print)

PATIENT INFORMATION

Today's date:	Email address:			
Child's last name:	First name:	Middle initial:	Birthdate:	Sex:
Legal name, if different than above:	Primary phone number:	Secondary phone number:	Social Security number:	
Address:				
Parent/Legal guardian name:	Parent/Legal guardian address:	Parent/Legal guardian phone number:		
Parent/Legal guardian date of birth:	School child attends:			

Does child receive free and/or reduced lunches: Yes No

INSURANCE INFORMATION *(please have insurance card available to make a copy)*

Person responsible for bill:	Birthdate:	Phone:
Address of responsible party, if different than above:	Is responsible party a patient at Clarity/Preferred Family? Yes No	
Employer:	Employer address:	
Employer phone number:	Patient's relationship to insurance subscriber: Child Step-child Other_____	

Primary insurance:

Medicare Medicaid Blue Cross/Blue Shield United Healthcare Other:_____

Subscriber's name:	Subscriber's Social Security number:	Subscriber's birthdate:
Policy number:	Group number:	Co-payment amount:

Secondary insurance, if applicable:

Medicare Medicaid Blue Cross/Blue Shield United Healthcare Other:_____

Subscriber's name:	Subscriber's Social Security number:	Subscriber's birthdate:
Policy number:	Group number:	Co-payment amount:

Patient's relationship to insurance subscriber:

Child Step-child Other:_____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Primary phone number:	Secondary phone number:

Please continue on next page.

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.

PLEASE CIRCLE RESPONSES TO EACH OF THE FOLLOWING CATEGORIES:

Ethnicity:
Hispanic or Latino
Non-Hispanic or Latino

Race:
Asian
Native Hawaiian
American Indian/Alaska Native
Other Pacific Islander
Black/African American
White (non-Hispanic or Latino)
Hispanic or Latino
Refuse to Report

Primary Language:
English
Other (specify):_____

Housing Status:
Own/Rent
Homeless
Transitional Housing
Doubling-up
Shelter

Marital Status:
Single
Widow
Married
Legally Separated
Divorced

Employment Status:
Patient: Part Full Student
Spouse: Part Full Unemployed

Gender Identity:
Male Female Decline
Neither
Transgender Male (F to M)
Transgender Female (M to F)

Sexual Orientation:
Straight
Don't know
Bisexual
Decline
Lesbian/Gay

How did you hear about Clarity?
Friend/Family Physician Billboard Health Fair
Newspaper/Magazine/Social Media Other:_____

Are you a Veteran?
Yes No

Do you have an Advanced Directive?
No Yes, agent:_____

Income verification Table *(please circle)*

Family Size	Income Range	Income Range	Income Range	Income Range	Income Range	Income Range
1	$0-$12,140	$12,141-$15,175	$15,176-$18,210	$18,211-$21,245	$21,246-$24,280	$24,281+
2	$0-$16,460	$16,461-$20,575	$20,576-$24,690	$24,691-$28,805	$28,806-$32,920	$32,921+
3	$0-$20,780	$20,781-$25,975	$25,976-$31,170	$31,171-$36,365	$36,366-$41,560	$41,561+
4	$0-$25,100	$25,101-$31,375	$31,376-$37,650	$37,651-$43,925	$43,926-$50,200	$50,201+
5	$0-$29,420	$29,421-$36,775	$36,776-$44,130	$44,131-$51,485	$51,486-$58,840	$58,851+
6	$0-$33,740	$33,741-$42,175	$42,176-$50,610	$50,611-$59,045	$39,046-$67,480	$67,481+
7	$0-$38,060	$38,061-$47,575	$47,576-$57,090	$57,091-$66,605	$66,606-$76,120	$76,121+
8	$0-$42,380	$42,381-$52,975	$52,976-$63,570	$63,571-$74,165	$74,166-$84,760	$84,761+

Insurance and Patient Responsibility: Insurance claims are submitted on your behalf by Clarity Healthcare. You are responsible for knowing what your insurance coverage is, and if our providers are in-network or not in-network with your insurance plan. For any questions regarding your coverage, we recommend you contact your carrier or plan provider directly. You will need to update or verify personal information at each visit. 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 $40 fee is expected to be paid in full at the time of service. If you can provider 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.

Photo Consent: I give my consent to have a photo taken for office identification purposes. This photograph will be kept confidential and stored in my electronic medical record at Clarity Healthcare.

Disclaimer: For the protection of your confidentiality, do you have any family members who work at Clarity Healthcare?
If so, who? _____

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 claim.

Patient/Guardian Signature:	Date: