



220 South Thomas Street
 Bedford, PA 15522
 Phone: 814-623-8222
 Fax: 814-623-2223



144 Fifth Avenue
 Hyndman, PA 15545
 Phone: 814-842-3206
 Fax: 814-842-3746

www.hyndmanhealth.org

Patient Registration

PATIENT'S NAME (PLEASE INCLUDE NAME SUFFIX IF APPLICABLE)			
LAST	FIRST	MIDDLE	MAIDEN OR SUFFIX
ADDRESS			
PO BOX/STREET	ZIP CODE	CITY	STATE
HOME PHONE NUMBER	CELL PHONE NUMBER	SOCIAL SECURITY NUMBER	SEX (CIRCLE ONE) MALE FEMALE
MARITAL STATUS (CIRCLE ONE) SINGLE MARRIED WIDOWED DIVORCED SEPARATED	BIRTHDATE	RACE (CIRCLE ONE) WHITE BLACK/AFRICAN AMERICAN AMERICAN INDIAN ALASKA NATIVE ASIAN PACIFIC ISLANDER UNREPORTED/REFUSED	
ALLERGIES (PLEASE CIRCLE ONE): YES NO IF YES, PLEASE LIST:		ETHNICITY (CIRCLE ONE) HISPANIC LATINO OTHER UNREPORTED/REFUSED VETERAN (CIRCLE ONE) YES NO	
EMERGENCY CONTACT INFORMATION			
CONTACT NAME	RELATIONSHIP	HOME PHONE NUMBER	CELL PHONE NUMBER
SECOND CONTACT NAME	RELATIONSHIP	HOME PHONE NUMBER	CELL PHONE NUMBER
NOTIFICATION AUTHORIZATION			
This is to obtain your preference for notification of lab and x-ray results or regarding information about medications (please check in the appropriate area)			
<input type="checkbox"/> 1. Try to contact me by telephone, but if you do not reach me directly, do not leave any type of message on the answering machine or with person answering the telephone			
<input type="checkbox"/> 2. If you do not reach me directly, by telephone, HAHC may leave actual results on answering machine or with person answering the telephone			
<input type="checkbox"/> 3. I would like to make other arrangement (please specify): <hr/> <hr/> <hr/>			

PATIENT'S EMPLOYMENT INFORMATION			
OCCUPATION		EMPLOYER'S NAME	
EMPLOYER'S ADDRESS			
STREET	ZIP CODE	CITY	STATE
EMPLOYER'S PHONE NUMBER			

GUARANTOR/PRIMARY INSURANCE CARDHOLDER'S INFORMATION

LAST NAME		FIRST NAME		MIDDLE	BIRTHDATE	
SOCIAL SECURITY NUMBER		OCCUPATION			SEX (CIRCLE ONE) MALE FEMALE	
GUARANTOR'S EMPLOYER NAME				EMPLOYERS' PHONE NUMBER		
GUARANTOR'S EMPLOYER ADDRESS						
PO BOX/STREET			ZIP CODE	CITY		STATE

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE NAME		POLICY NUMBER		GROUP NUMBER	INSURANCE PHONE NUMBER	
INSURANCE STREET ADDRESS			ZIP CODE	CITY		STATE
SECONDARY INSURANCE NAME		POLICY NUMBER		GROUP NUMBER	INSURANCE PHONE NUMBER	

DENTAL INSURANCE INFORMATION (if applicable)

PRIMARY INSURANCE NAME		POLICY NUMBER		GROUP NUMBER	INSURANCE PHONE NUMBER	
INSURANCE STREET ADDRESS			ZIP CODE	CITY		STATE

PRESCRIPTION INSURANCE INFORMATION (if applicable)

PRIMARY INSURANCE NAME		POLICY NUMBER		GROUP NUMBER	INSURANCE PHONE NUMBER	
INSURANCE STREET ADDRESS			ZIP CODE	CITY		STATE
SECONDARY INSURANCE NAME		POLICY NUMBER		GROUP NUMBER	INSURANCE PHONE NUMBER	

PATIENT'S PHARMACY INFORMATION

PHARMACY NAME			PHARMACY TELEPHONE NUMBER			
ADDRESS:		ZIP CODE	CITY		STATE	

This information is required as HAHC submits prescriptions electronically.

Income Verification

HAHC offers a sliding fee scale based on income and family size to all patients. To see if you will qualify please complete the following. **Proof of income will be required before receiving the sliding fee discount.**

Your Family Size and Income – first find and circle your family size, then go across that line, find and check the annual income range for your family.

Family size 1 person:	€ \$0 - \$11,170	€ \$11,171 - \$22,340	€ \$22,341 & above
Family size 2 people:	€ \$0 - \$15,130	€ \$15,131 - \$30,260	€ \$30,261 & above
Family size 3 people:	€ \$0 - \$19,090	€ \$19,091 - \$38,180	€ \$38,181 & above
Family size 4 people:	€ \$0 - \$23,050	€ \$23,051 - \$46,100	€ \$46,101 & above
Family size 5 people:	€ \$0 - \$27,010	€ \$27,011 - \$54,020	€ \$54,021 & above
Family size 6 people:	€ \$0 - \$30,970	€ \$30,971 - \$61,940	€ \$61,941 & above
Family size 7 people:	€ \$0 - \$34,930	€ \$34,931 - \$69,860	€ \$69,861 & above
Family size 8 people:	€ \$0 - \$38,890	€ \$38,891 - \$77,780	€ \$77,781 & above

For each additional person over 8 family members add: \$3,960

CONSENT, ASSIGNMENT AND RELEASE

1. I _____ give permission for Hyndman Area Health Center, Inc. to give me treatment.
(patient name)

2. I request that payment of authorized benefits is made on my behalf to the Hyndman Area Health Center, Inc. for any services rendered to me by their medical and/or dental providers. I authorize Hyndman Area Health Center, Inc. to release medical and/or dental information to my current insurance company and its agents to determine these benefits or the benefits payable for related services.

I understand that:

- Hyndman Area Health Center will have to send my health information to my insurance company.
- I must pay my share of the costs when I receive my treatment.
- I must pay for the cost of these services if my insurance does not pay after 90 days or if I do not have insurance.

3. I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.
- I may request a copy of HAHC's Notice of Privacy Practice at any time.

4. I have read the consent to treat or have had this consent read to me.

5. I have been able to ask questions and my questions were fully answered.

Patient's Signature

Date

Parent or Guardian Signature
(for children under 18)

Date

Print Name