Patient Registration Form

Date ___ /____/ _____

How did you hear about us?

☐ Family/Friend ☐ Medical Provider ☐ Other
☐ Internet Search ☐ Social Media
☐ Case Manager ☐ Advertisement

PATIENT INFORMATION (PLEASE PRESENT YOUR PHOTO IDENTIFICATION AND INSURANCE CARD WITH THIS PAPERWORK)

☐Mr. ☐Ms. ☐Mrs. ☐Dr. ☐Miss ☐Mx. Legal Name: First | Middle | Last | Suffix (Jr, Sr, II, III, etc.)

Affirmed Name/Nickname

Birth Date: Mon ______ / Day ______ / Year ______

Are you - the patient - responsible for all bills and insurance? ______________

If not, please list the name of the responsible person. ____________________

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

Street Address | Apt/Ste/Unit | City | State | Zip

Mobile/Cell Phone ( ) | Home Phone ( ) | Email Address

Best way to contact me or leave messages (check all that apply):
☐ Phone/Voicemail ☐ Text ☐ E-Mail ☐ U.S. Mail

Gender Listed on Insurance or Driver's License
☐Male ☐Female ☐Non-Binary

Social Security Number _________ -__________- _________

Occupation | Employer | Work Phone

Emergency Contact | Phone | Relationship to Patient

INSURANCE (PLEASE GIVE YOUR INSURANCE CARD TO THE FRONT DESK STAFF MEMBER)

Legal Name of Person Responsible for Bill ☐ Same as Above | Relationship to Patient if Patient is not Responsible Party

Birth Date (if the patient is not responsible party) ________ /________/________

Social Sec Number of Responsible Party _________ -________- _________

Street Address (if different) | City | State | Zip

Email Address | Home Phone ( ) | Cell Phone ( ) | Work Phone ( )

Primary Insurance Company | Subscriber's Name | ID# | Group#

Secondary Insurance Company | Subscriber's Name | ID# | Group#

Patient Registration Form

INCOME: (PLEASE GIVE VERIFICATION OF INCOME TO A PATIENT REPRESENTATIVE IF APPLYING FOR SLIDING FEE or RYAN WHITE GRANT FUNDS)

Annual Income: $ ________________________ Household Annual income: $ ____________________

Number of adults in household (including you): _________ Number of children in household (under 18 years old): _________

AR Health receives funding to provide financial benefits to patients. By providing proof of income, AR Health can determine whether you are eligible for these benefits. Proof of your income includes, but is not limited to, your last two to three pay stubs, last year's W-2 form, or last year's tax return.

By signing, I understand that I may be eligible for the AR Health sliding scale or Ryan White financial benefits based on my income. However, I must provide proof of income to receive these benefits. I understand that I will be charged the full fee of my visit if I do not bring in income documentation by my third visit or within 60 days of my first visit, whichever comes first. I understand that I will never be refused services at AR Health because I do not provide documentation of income.

Patient Signature____Date________/________/ ________

DISCLAIMER STATEMENT

I authorize AR Health to submit claims to my insurance carrier and to release any medical information necessary to process all claims. I also authorize payment for any medical benefits to AR Health for all services provided until further notified for this account. I agree that I am financially responsible for any co-pay and self-pay balance at the time of service, and any balance that may be due after the claims have been

Patient Signature ________________________________ Date_____________

Office use only:

- ☐ All documents signed
- ☐ ID scanned
- ☐ Insurance scanned
- ☐ Correct insurance information entered
- ☐ Affirmed name entered

Office Staff Initials: ____________

Demographics Form

Name on ID/Insurance: First	Middle	Last	New Patient? ☐ Yes ☐ No
Chosen First Name:	Birth Date: Month / Day / Year		

Have you attended AIDS Resource outreach events? ☐ Yes ☐ No
Do you receive public benefits (SNAP, Access (medical card), etc.)? ☐ Yes ☐ No

Pronouns: ☐ He/him ☐ She/her ☐ They/them ☐ Only my name ☐ No preference ☐ A pronoun not listed

We require the following information to help our staff use the most respectful language when addressing you, better understand our population, and fulfill our grant reporting requirements. Our funders provided the options for some of these questions; we understand that current demographic categories do not adequately capture our individual identities. Please help us serve you better by selecting the best answers to these questions. Thank you.

Preferred Spoken and Written Language:
- ☐ English
- ☐ Spanish
- ☐ American Sign Language
- ☐ Other: ____________

Language Interpretation Services Needed?
- ☐ No
- ☐ Yes Language: ____________

Ethnicity:
- ☐ Hispanic/Latinx
- ☐ Mexican
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other
- ☐ Not Hispanic/Latinx
- ☐ Decline to Answer

Race: Select up to two*
- ☐ African
- ☐ Black American
- ☐ White/Caucasian
- ☐ Asian
- ☐ Asian American
- ☐ Native American
- ☐ Alaska Native
- ☐ Native Hawaiian/Pacific Islander
- ☐ Decline to Answer
- ☐ Other (please specify): ____________

Housing Status:
- ☐ Permanent Housing
- ☐ Non-Permanent Housing
- ☐ Institution
- ☐ Unhoused
- ☐ Transitional Shelter
- ☐ Doubling Up (not paying rent)
- ☐ Couch Surfing
- ☐ Other
- ☐ Decline to Answer

Sexual Orientation:
- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Queer
- ☐ Straight
- ☐ Questioning
- ☐ Intersex
- ☐ Asexual
- ☐ Two Spirit
- ☐ Decline to Answer
- ☐ Something Else

Sex Assigned at Birth:
- ☐ Male
- ☐ Female
- ☐ Intersex
- ☐ Decline to Answer

Completed Level of Education:
- ☐ 1-8 Years
- ☐ High School Degree
- ☐ GED
- ☐ Trade School
- ☐ Some College
- ☐ Associate's College Degree
- ☐ Bachelor's College Degree
- ☐ Master's Degree
- ☐ Doctorate Degree
- ☐ Decline to Answer

Income (if applying for sliding scale fees)

Anticipated annual household income for this year: ____________	Total # people living in household, including you: ____________

I verify that the above information is correct to the best of my knowledge.

_______________________________________ ______/_______/______

Patient Signature Date

_______________________________________ _______/______/______

Parent/Guardian Signature if patient is under 18 Date

Sliding Fee Application

It is the policy of AR Health to provide quality medical care to all people in need of care, regardless of income and/or the inability to pay. Please complete the following information so that AR Health can determine your eligibility for discounted services. You will be reassessed for the sliding scale every six months, and you will be required to provide updated proof of income.

Patient's Name: ____Affirmed Name: ________________________

Date of Birth: ____________________________Last four digits of Social Security Number: _______________

Do you have commercial health insurance, Medicare, and/or Medicaid?

☐ Yes ☐ No ☐ Not Sure

HOUSEHOLD

A "household" includes legal children, a civil union partner, a married spouse, and legal dependents. Please list the names of individuals in your household and their relation to you. Please use the back of this form for additional space.

Names of individuals living in the household (including yourself)	Relationship to you
TOTAL number of people in household:	

ANNUAL HOUSEHOLD INCOME

Source of Income	Self	Partner	Other	Total
Gross wages, salaries, tips, etc.				
Social Security (SSI or SSDI)				
Unemployment Benefits				
Investment Income				
Other				
TOTAL INCOME				

PLEASE READ AND SIGN

I have reviewed this form and certify that the information I provided is true and correct to the best of my knowledge. I understand that I am personally responsible for all health center charges until such time as I have supplied the necessary documentation to support my application. I understand that I will be charged the full fee of my visit if I do not bring in income documentation by my third visit or within 60 days of my first visit, whichever comes first. I understand that I am required to notify AR Health if my income level changes or if I become insured. If there are changes, I will be re-assessed for the sliding fee scale.

Print Name: ____

Patient Signature: ______________________________ Date: ______________

Guardian Signature (if applicable): ______________________________

FOR INTERNAL USE ONLY

☐ $0 RW 0-100%

☐ $5 Non-RW 0-100%

☐ $10 101-125%

☐ $15 126-150%

☐ $20 151-175%

☐ $25 176-200%

☐ Full Fee (not eligible) greater than 200%

Reviewed By	
Effective Date	
Termination Date	

Registration Receipt of Documents

Legal Name of Patient: ____

Affirmed Name of Patient: ____

Date of Birth:__________/_______/ _______

HIPAA Privacy Practices Acknowledgement
Notice of Privacy: AR Health's Notice of Privacy Practices was given to you when you registered. By initialing below, you acknowledge that you have received the Notice of Privacy Practices.

Initial Here______________ Parent/Guardian initial if under 18 _____________

Patient Rights and Responsibilities Acknowledgement
Rights and Responsibilities: A copy of AR Health's Patient Rights and Responsibilities was given to you when you registered. You have read the Rights and Responsibilities and had any questions about them answered. By initialing below, you acknowledge that you received a copy of the Rights and Responsibilities and that you understand them.

Initial Here______________ Parent/Guardian initial if under 18 _____________

Complaint Process Acknowledgement
Grievance Policy: AR Health's Complaint Process was given to you when you registered. By initialing below, you acknowledge that you received the Complaint Process.

Initial Here______________ Parent/Guardian initial if under 18 _____________

Consent for Treatment Acknowledgement
Consent for Treatment: AR Health's Consent for Treatment was given to you when you registered. You have read the Consent for Treatment and had any questions about it answered. By initialing below, you acknowledge that you received the Consent for Treatment and understand it.

Initial Here______________

Patient Signature: ____________________________________ Date: __________

Guardian Signature:
____
(If different from the Patient listed) Date: __________

Employee Witness to Signature:
____ Date: __________

AUTHORIZATION FOR RELEASE OF INFORMATION

Name on medical record: ____________________________ **Date of Birth:** ___________ **SSN:** ______________________

Address: ____ **City:** ____

State: ___________________________ **Zip:** ________________________________ **Phone:** _________________________

I hereby authorize and request that:

AR Health, 500 W 3rd St, Williamsport PA 17701
129 S Sparks St, State College, PA 16801
570-322-8448 phone/570-322-8648 fax

Disclose Information *TO:* ____
Receive information *FROM:* _
Exchange information *WITH:*

City:________________________ State:________ Zip:___________

Phone:_____________________ Fax:________________________________

Purpose of disclosure:_________________**Date or range of dates of requested information:**_________________

I request the release of the following information (INITIAL ALL THAT APPLY):

_____ Complete Health Record
____ Discharge Summary
____ History and Physical Exams
____Physician/Consultation Reports
_____ X-Rays
_____ Radiology
_____ EKG/EEG
_____ Progress Notes
_____ Lab Tests/Reports
_____ Case Management Notes/Reports
_____ Other (specify):_____________________
____

The release of information on certain conditions/treatments requires my specific authorization. WITHOUT THIS AUTHORIZATION, THIS INFORMATION WILL NOT BE RELEASED. I authorize the release of information relating to the following (INITIAL ALL THAT APPLY):

__________Mental/Behavioral Health
__________Developmental Disability
__________Alcohol/Substance Abuse
____Domestic Violence/Sexual Assault
___________Sexually Transmitted Diseases
___________HIV or AIDS
___________DNA Testing/Genetic Disorders
___________ANY AND ALL OF THE ABOVE-LISTED CONDITIONS/TREATMENTS

If requesting email delivery, you must initial and complete the following:

_______(initial) I hereby authorize that any of the information requested above may be delivered via secure, encrypted email to the following email address: ____

This Authorization is valid until (SELECT DATE NO MORE THAN 12 MONTHS FROM SIGNATURE):______________________________

(Continued)

I understand that this authorization is voluntary, and I may revoke this authorization at any time by writing to the address above. Any revocation does not apply to records already released in good faith pursuant to the above release. I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I understand I have the right to inspect and copy the information being disclosed pursuant to this authorization. I understand that a medical provider to whom this authorization is furnished may not condition their treatment of me on whether or not I sign the authorization, but it has been explained to me that if I decline to consent to this release of information, the following consequences may apply, as relevant: my providers may be unable to coordinate my care; I may be unable to apply for this program; and/or the requested records may not be released. Any copy of this authorization shall be considered as valid as the original.

Signature of Person Authorizing Release Date Signature of Witness (encouraged but not required) Date

NOTE: This Authorization must be completed in its entirety in order to be valid. If the authorization signature is from a person other than the person receiving care, indicate the basis of the authorization and consent:____

Consent for Treatment

I agree to receive routine treatments and procedures that my medical provider believes will help improve my health. A "routine" treatment or procedure is regularly offered in an outpatient clinic like AR Health. I understand that my medical provider will work with me to diagnose and treat my health issues. Therefore, I agree to receive medicine and/or treatment that my medical provider believes will help to diagnose and/or treat problems I am having or improve my health and wellness.

Routine medical treatments and procedures at AR Health may include:

- Asking questions about my medical history and my health
- A physical exam
- Measuring my blood pressure, temperature, height, and weight
- Prescribing and/or giving me medicine
- Having blood drawn for tests
- Screening for infectious diseases such as HIV, HCV, Syphilis, Chlamydia, or Gonorrhea
- Standard preventative examination
- Point of service tests
- Other simple, common procedures

As mutually agreed upon with the provider

Routine therapy treatments and procedures may include:

- Asking questions about my mental health history and how I am feeling
- Discussing my concerns and problems
- Creating a plan for therapy together

If my provider recommends any "non-routine" treatments, procedures, or medicines, we will discuss them separately. I may get a special consent form for non-routine care that my medical provider will explain and review with me.

I understand that:

- AR Health cannot promise that I will get good results from the treatment, procedures, services, and medicine I receive.
- My medical provider will explain the benefits and possible risks of the routine treatment, procedures, services, and medication I may receive and will tell me about other options, too.
- I will have a chance to ask questions and get answers to any concerns.
- I will be able to choose the treatments, procedures, services, and medicines suggested to me. I can choose to take some and refuse other treatments, procedures, services, and medicines suggested to me.
- I can change my mind about the services I want at any time, but AR Health cannot reverse the care I have already received.

- If I refuse to consent to treatment as outlined above, I cannot be treated at AR Health. Instead, AR Health will refer me to other providers or healthcare agencies.

I understand that the staff works together to provide integrated healthcare and to provide me with a strongly positive and comprehensive experience. To do that, information about me may be shared with other necessary AR Health staff involved in my care, such as my nurse, medical provider, and case manager (where applicable).

I understand that the information I give AR Health is confidential and cannot be shared with anyone outside of AR Health without my written permission except as required by law. I understand that if I am eligible for and participate in screening for HIV or other STIs, positive results will be reported to the PA Department of Health. I understand that AR Health may have to share some information with outside organizations about me without my explicit permission when any of the following things happen:

- If AR Health finds out about or suspects child abuse, elder abuse, or abuse of someone disabled, it is required to report information to protect the person who may be abused.
- If AR Health believes that I am at a high risk of hurting or killing myself or someone else, AR Health has to help keep the other person and me safe.
- If AR Health diagnoses a reportable illness/disease as specified by the Pennsylvania Department of Health.

For more information about how my information can, cannot, or must be shared, I can review the AR Health Privacy Policies and the AR Health Patient Rights and Responsibilities.

Statement of Patient Rights

You have the right:

- To access services that will not be denied on the basis of economic status, disability, national origin, ethnicity, race, religion, gender, gender presentation or gender identity, sexual orientation, political views, weight, or HIV status (in accordance with the Americans with Disabilities Act).
- To be treated as an important member of your healthcare team and to have your choices and needs valued.
- To receive care in a safe and secure environment, free from physical, verbal, or sexual harassment, profanity, or disorderly conduct.
- To have all information about you, including HIV status, treated in a confidential manner in accordance with Federal and State laws.
- To receive information about your diagnosis, medical condition, and treatment in a language you understand.
- To request a copy of your medical records.
- To receive services from other organizations with or without the assistance of AR Health staff.
- To refuse service or end your participation in any or all services provided by AR Health and to have the consequences of this decision explained to you without punishment or penalty.
- To know where and how to register a complaint or concern and to know that your complaint or concern will be taken seriously.
- To know that you will not be penalized for registering a complaint or concern.
- To ask for the services of an interpreter and to know that AR Health will provide one at no cost to you.
- To continue to receive services if your financial circumstances or insured status has changed.
- To contact AR Health to raise concerns about any errors on your bill.

Statement of Patient Responsibilities

You have the responsibility:

- To be an active member of your health care team and follow the treatment plan you and your provider agree upon.
- To ask questions and tell us when you do not understand a treatment option or decision being considered.
- To help your provider understand your concerns and the way your life circumstances may impact your care.
- To keep your provider informed of all services you receive from outside agencies or individuals, in particular, other medications you are prescribed by other providers.
- To notify AR Health immediately if your contact information, personal information, insurance status, or financial circumstances change.
- To come to your appointment without being under the influence of alcohol or illicit drugs. If you are under the influence of alcohol or other illicit substances, you will not be seen, and you will be asked to reschedule your appointment.
- To attend your appointment(s) and arrive 10-15 minutes before your scheduled appointment time.
- Please provide at least 24 hours advance notice if you need to cancel your appointment.
- To answer all questions and fill out all paperwork completely and honestly, including (but not limited to) information about your financial status, health conditions, use of illicit substances, and care received elsewhere.
- To treat everyone at AR Health with respect. Physical, verbal, or sexual harassment of staff or other patients, swearing, threatening AR Health providers or staff, or disorderly conduct will not be tolerated. This type of behavior may result in immediate termination from AR Health services.
- To pay your bills or make arrangements with AR Health to meet your financial obligations in a timely manner.
- To share your compliments and concerns and provide suggestions to help us provide you with the best care possible.

Description of Services and Complaint Process

AR Health promotes the health and well-being of people living with HIV or AIDS and people who are gay, lesbian, bisexual, transgender, queer, questioning, intersex, asexual, and two-spirit and enhances their lives through healthcare and wellness programs. AR Health offers primary medical care and limited case management services. Our services are designed to serve gay, lesbian, bisexual, transgender, queer, questioning, asexual, intersex, and two-spirit people and people impacted by HIV or AIDS in a confidential, supportive environment.

DESCRIPTION OF SERVICES

MEDICAL CARE: Anyone is eligible to receive care based on availability regardless of ability to pay. Services include comprehensive primary care, HIV testing, and counseling.
CASE MANAGEMENT: Anyone who is living with HIV is eligible to receive case management. Services include needs assessment, development of a service plan, medical case management, treatment adherence, support with accessing benefits and entitlement programs, resource referral, emergency financial aid, housing assistance, transportation, legal assistance, and more.

Effective 02/01/2022
Updated 9/10/2024

COMPLAINT PROCESS

We appreciate patient feedback and encourage you to offer us the opportunity to address any concerns you may have. If you feel you have not been treated fairly, that your rights have been violated, or that the quality of the services you received was poor, please consider taking one of the following steps:

- If you feel comfortable, please discuss your concern with the doctor or staff member offering your services. They will attempt to resolve the complaint and inform you about the available alternatives or actions they can take to resolve your concern.

- If you are uncomfortable speaking directly with the doctor or staff member or are still dissatisfied after speaking with them, you can speak with the Executive Director. The Executive Director will attempt to resolve the complaint and inform you about the available alternatives or actions they can take to resolve your concern. If the Executive Director is not immediately available, the Executive Director will attempt to contact you as soon as possible, but no later than two business days.

- If you are unsatisfied with the Executive Director's response and proposed solution, you can ask the Board of Directors for a response and proposed resolution.

- If at any time, you are uncomfortable speaking with anyone directly about your complaint, you fill out a Patient Complaint and Grievance Form that includes a written description of 1) the circumstances surrounding the complaint, 2) actions AR Health staff took to resolve the complaint to date and 3) the action you are requesting to resolve the complaint.

Patient Complaint and Grievance Forms are available at the front desk and on the AR Health website. You may leave the form at the front desk, email it to admin@arhealthservices.org, or mail it to the Grievance Officer at PO Box 1062, Williamsport, PA 17703.

Effective 02/01/2022
Updated 9/10/2024