SACRED CIRCLE HEALTHCARE
A HEALTH DIVISION OF CTGR

660 South 200 East Ste. 250 Salt Lake City, UT 84111
Phone: 801-359-2256 Fax: 801-364-4392

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ❑ Male ❑ Female	MARITAL STATUS ❑ Single ❑ Married ❑ Other_____

Email:

Ethnicity:
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino
- ❑ Refused to Report

Language:
- ❑ English
- ❑ Spanish
- ❑ Other, please list below

Race:
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ Black or African American
- ❑ White
- ❑ Hispanic
- ❑ Other Pacific Islander
- ❑ Other Race
- ❑ Unreported/Refused to Report

CTGR Member: ❑ Yes ❑ No **Non CTGR Tribal Affiliation:**

Enrollment ID:

Refugee: ❑ Yes ❑ No

PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)	EMPLOYER PHONE

Is the patient a minor child and do you authorize a different adult (non-parent or Guardian at least 18 years old) to consent to care in your absence? ❑ Yes ❑ No
Authorized Adult:

Does this consent include procedures, immunizations, and prescribing medications? ❑ Yes ❑ No

INSURED/RESPONSIBLE PARTY INFORMATION Responsible Party ❑ Another Patient ❑ Guarantor ❑ Self

Relation to Insured ❑ Parent ❑ Guardian ❑ Other: Please specify

NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE	
GROUP NUMBER	SUBSCRIBER/ID NUMBER	EMPLOYER	EMPLOYER PHONE
SECONDARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE	
GROUP NUMBER	SUBSCRIBER/ID NUMBER	EMPLOYER	EMPLOYER PHONE

PRIMARY DOCTOR/FAMILY DOCTOR	REFERRING DOCTOR	
IN CASE OF EMERGENCY CONTACT:	RELATIONSHIP	PHONE NUMBER
Does the above mentioned emergency contact have permission to discuss your protected health information: Yes_____ No _____	Preferred Pharmacy/Location:	

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PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

NOTICE OF PRIVACY PRACTICES

_____ **(Patient Initials)** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

RELEASE OF INFORMATION

_____ **(Patient Initials)** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other Sacred Circle affiliated facilities may be made available to subsequent Sacred Circle affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other healthcare industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

DISCLOSURES TO FRIENDS AND/OR FAMILY MEMBERS

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

AUTHORIZATION TO RELEASE INFORMATION TO:

Name(s)	**Relationship:**	**Contact Number:**
Name(s)	**Relationship:**	**Contact Number:**

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

PRESCRIPTION ORDER PICK-UP

There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. For us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

I wish to designate individual(s) to pick up a prescription order on my behalf: ❑ **Yes** ❑ **No**

Name(s)	Name(s)

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PATIENT FINANCIAL POLICY

_____ **(Patient Initials)** I acknowledge that I have received, reviewed, understand, and will comply with the policies explained in the Sacred Circle Health Care Financial Policy Form. There is a detailed form available upon request.

CONSENT FOR PHOTOGRAPHING OR OTHER RECORDING FOR SECURITY AND/OR HEALTH CARE OPERATIONS

_____ **(Patient Initials)** I consent to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recording will be securely stored and protected. Images and/or recordings in which I am identified will not be released and or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted by law.

CONSENT TO EMAIL OR TEXT MESSAGE USAGE FOR APPOINMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS:

We want to stay connected with our patients.
Patients in our practice may be contacted vial email and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email address or text number below, you understand that you may get these communications from the practice. You may opt out of these communications at any time. The practice does not charge for this service, but standard messaging rates may apply as provided in your wireless plan (contact your wireless carrier for pricing plans and details).

CELL PHONE AUTHORIZED:	**EMAIL AUTHORIZED:**

Opt Out of text and email alerts ❑ **Yes** ❑ **No**

PATIENT ATTESTATION:

I attest that all of the information providers is correct and true to the best of my knowledge.

Patient/Parent/Guardian/Patient Representative Signature:	**Date:**
Patient/Parent/Guardian/Patient Representative Name (Printed):	**Date:**
Witness Signature	**Date:**