PINAL COUNTY
WIDE OPEN OPPORTUNITY

PINAL COUNTY PUBLIC HEALTH SERVICES DISTRICT
CLIENT REGISTRATION FORM

CLIENT INFORMATION

Last name:	First:	Middle Initial:
Maiden name or other aliases:		
Birthdate: / Age:	Gender at Birth: ☐ Male ☐ Female	
Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed		
Mailing Address:	Apartment #:	
City:	State:	ZIP Code:
Home phone:	Work phone:	Mobile phone:
Email address:	May we contact you or send you bills at home?: ☐ Yes ☐ No	
I would prefer to be contacted by: ☐ Mail ☐ Home Phone ☐ Work Phone ☐ Mobile Phone		
Primary Care Provider (PCP) Name:	Phone Number:	
Race: ☐ American Indian or Alaska Native ☐ African-American/Black ☐ White ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Other		
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown	Preferred Language:	
How did you hear about us? ☐ Friend or word of Mouth ☐ Partner ☐ Text Message ☐ Phone call from Public Health ☐ Provider ☐ County Website ☐ Online ad ☐ Community/work event ☐ School ☐ Brochure/Flyer ☐ Other: _____		

INSURANCE INFORMATION (AHCCCS IS CONSIDERED AN INSURANCE)

Insurance: ☐ None ☐ Underinsured(not covered by insurance) ☐ KidsCare ☐ AHCCCS ☐ Don't Know
☐ Native American/Alaskan Native, Tribe: _____ ☐ Other: _____

Insurance Name:	Policy#:	Group#:
Policy Holder Last Name:	First Name:	Birthdate:
Policy Holder Social Security Number:	Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other	

May we bill your Health Insurance? ☐ Yes ☐ No (If yes, correspondence may be sent to your mailing address)

☐ I am uninsured and would like information about AHCCCS and the Affordable Care Act

IN CASE OF EMERGENCY

Name of friend/relative that we may contact:	Relationship to Client:	Home phone:	Other phone:

FINANCIAL INFORMATION (Family Planning only)

Total Yearly household income: $ _____ How many people are in your household, including yourself? _____

Staff Only:

Federal guidelines	Fee Scale	Assigned Source of Payment
_____ %	☐ No Fee ☐ Partial Fee ☐ Full Fee	☐ Title X ☐ AHCCCS ☐ Self ☐ Private Insurance ☐ Title X Declined ☐ Other:_____

SIGNATURE

By signing below, I agree to allow Pinal County Public Health Services District to provide preventative medical services to the patient named above and understand that some services may have a fee. I understand that I am financially responsible for all charges whether or not covered by insurance. Acceptance of services is voluntary and is not a pre-requisite to eligibility for, or receipt of any services or any other program of the applicant. I understand that all my medical information provided in the course of this service are CONFIDENTIAL, and under HIPAA protection, and agree that I have been given information on my privacy rights under HIPAA. I understand that if I receive HIV testing or counseling services, that information will be part of my confidential medical record unless otherwise specified.

Minor Patients Only (Age 17 and under) I understand the importance of involving my parent in the decision-making regarding sexual activity and contraceptive use. I understand fees will be based on my income if my parents are not involved with my decision. I realize that as a minor, the reporting of sexual abuse, physical neglect, incest, sexual molestation, sexual coercion or sexual assault to the Department of Child Safety is required by law, if there are reasonable grounds to believe I have been a victim of such conduct. This is the only exception to protection of my confidentiality unless records are requested under subpoena.

_____ _____

Client/Guardian signature *Date*

_____ _____

Guardian Name (Please Print) *Relationship*

Leo Lew
Assistant County Manager

Administrative Services

PINAL COUNTY PUBLIC HEALTH

Louis Andersen
County Manager

Pinal County Public Health Services District
(PCPHSD)

PATIENT RIGHTS

Your individual treatment at this facility will be provided with dignity, respect, and consideration.

1. You have the right to not be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis; to receive treatment that supports and respects your individual choices, strengths, and abilities.

2. Your privacy will be protected. Your examination, treatment and discussions with your clinicians will be kept confidential by the health care providers involved with your care. In addition, all communications and records pertaining to your medical care will be held in strict confidence. You may approve or refuse the release of your medical records to any individual outside the facility, except as otherwise provided by law or third party contract.

3. You have the right to review, upon request, your own medical records.

4. You have the right to participate or have your own representative participate in the development of, or decisions concerning, treatment.

5. You have the right to receive assistance from a family member, representative, or other individual in understanding, protecting, or exercising your patient rights.

6. You will know the identity and professional title of the person(s) providing care for you.

7. You will receive from your clinician, complete and current information regarding the diagnosis, treatment options, alternatives to treatment, and prognosis of your condition in terms that you can understand. You have the right and responsibility to participate in decisions involving your health care.

8. You have the right to refuse treatment and to be informed of the potential consequences of any such action. You have the right to refuse to participate in experimental research and/or treatment.
9. You have the right to expect reasonable continuity of care, within the limitations of available appointment times and clinicians.

10. If it is medically appropriate to refer or transfer you to another health care provider, you will receive complete information and explanation concerning the need for, and alternatives to, such a referral or transfer.

11. You have the right to receive an explanation of any bill coming from the Pinal County Public Health Services District

PINAL COUNTY
PUBLIC HEALTH

PATIENT RESPONSIBILITIES

Patients have responsibilities as well as rights. Patients can help themselves by being responsible in the following ways:

1. You are responsible for keeping your appointments at the PCPHSD. If you cannot keep an appointment, it is your responsibility to notify us at least 24 hours ahead so that another client can be seen during that time.

2. You have the responsibility to treat health care professionals with respect and consideration.

3. You are responsible for being honest and direct about anything related to your health care. It is your responsibility to tell your clinician about any changes in your health.

4. You are responsible for understanding your health problems. If you do not understand your illness or treatment, it is your responsibility to ask your clinician about it.

5. It is your responsibility to tell your clinician if you are not able or willing to follow the treatment plan prescribed for you.

6. It is your responsibility to know the names and uses of the medications you are taking.

GRIEVANCE PROCEDURE

You have the right to grieve, formally or informally, any part of the care or treatment you receive at the Pinal County Public Health Services District.

The grievance process steps are:
· Verbal complaint to Clinical Services staff or supervisor.
· Verbal or written complaint directly to PCPHSD at 1-866-960-0633
· If the PCPHSD does not resolve your grievance, you may forwarded to:

Arizona Department of Health Services Public Health Licensing Services
Bureau of Medical Facilities Licensing
150 N. 18th Ave., Suite 450
Phoenix, Az 85007-3245
602.364.3030

I have received a copy of the Pinal County Public Health Services District Clients Rights.

Client's Name_____ Date _____

Signature _____