MACT Mariposa Amador Calaveras Tuolumne HEALTH BOARD INC

A Non-Profit Tribal Corporation

New Patient Registration (Adult Packet)

Section 1. Instructions

Return completed forms and supporting documentation to your local MACT Clinic or:

Mail: MACT Health Board, Inc.
Health Information Management
PO Box 939
Angels Camp, CA 95222

Fax: (209) 674-6200
Email: registration@macthealth.org
Phone: (209) 754-6262

Registration forms and supporting documentation will be reviewed for completeness and processed in the order received. **Incomplete forms will not be processed and will delay your ability to establish care.** Once registration forms have been processed, you will be contacted to schedule your first appointment.

Section 2. Locations and Services

Please select the location and services that are of interest. Not all services are offered in all locations. Some services may be limited to American Indian/Alaska Native patients-only. A representative will contact you with alternative options if we are unable to accommodate your primary preference(s).

Locations: ☐ Jackson ☐ Mariposa ☐ San Andreas ☐ Sonora ☐Ione ☐ Angels Camp

Services: ☐ Behavioral Health ☐ Dental ☐ Medical ☐ Optometry ☐ Women's Health ☐ Chiropractic ☐ Orthopedics

Section 3. Pain Management Agreement

MACT Health Board, Inc. is not a pain management clinic. I understand I will not be seen for pain management. ____
Initial

Section 4. Patient Information

Patient's Legal Name: _____ _____ _____
First Middle Last

Gender Identity: ☐ Male ☐ Female ☐ Other: _____ **Date of Birth**: _____

Social Security Number[1]: _____ **Primary Language**: _____

[1] Failure to provide a social security number (SSN) or individual taxpayer identification number (ITIN) may prevent your ability to establish care and/or continue to receive services at MACT Health Board, Inc.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Veteran Status**: ☐ Yes ☐ No

Mailing Address: _____

City: _____ **State**: _____ **Zip**: _____

Physical Address: _____

City: _____ **State**: _____ **Zip**: _____

Phone: _____ _____ _____
Home Work Cell

Email Address: _____ **Employer**: _____

Preferred Contact: ☐ Home ☐ Cell ☐ Work **Okay to leave a detailed message?** ☐ Yes ☐ No

American Indian or Native Alaskan Eligibility
Note: Priority access is given to American Indian and Alaska Native patients.

_____ _____ _____ _____
Tribe of Membership | Roll Number | Certificate of Indian Blood (CIB) | State Where Enrolled

Race and Ethnicity
Please check one box that best describes your race or ethnicity.

☐ American Indian/Alaska Native
☐ Black or African American
☐ Hispanic or Latino[1]
☐ White
☐ Multiple Races[2]

Asian
☐ Multiple Asian[3]
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Indian
☐ Japanese
☐ Korean
☐ Laotian
☐ Other Asian
☐ Vietnamese

Pacific Islander
☐ Multiple Pacific Islander[4]
☐ Guamanian
☐ Hawaiian
☐ Samoan
☐ Other Pacific Islander

[1] If you identify with Hispanic or Latino (alone or in combination with any other race). [2] If you identify with more than one race that is not Hispanic or Latino, select Multiple Races. [3] If you identify with more than one Asian ethnicity, select Multiple Asian. [4] If you identify with more than one Pacific Islander ethnicity, select Multiple Pacific Islander.

Section 5. Insurance Information

Do you have insurance? ☐ Yes ☐ No **Are you interested in our sliding fee scale?** ☐ Yes ☐ No

If you have insurance, MACT Health Board, Inc. requires a copy of the front and back of your insurance card(s) for insurance eligibility/verification purposes, as well as prescription drug-related matters. Please attach a copy of the **front and back** of your insurance card(s) with this packet. **If you are unable to provide a copy of your insurance card(s) with this registration packet, you must bring them to your first appointment.**

Medical Insurance

Primary Insurance Company: _____ ☐ N/A

Policy Number: _____ **Group Number**: _____

Guarantor Name: _____ **Date of Birth**: _____

Secondary Insurance Company: _____ ☐ N/A

Policy Number: _____ **Group Number**: _____

Guarantor Name: _____ **Date of Birth**: _____

Dental Insurance

Primary Insurance Company: _____ ☐ N/A

Policy Number: _____ **Group Number**: _____

Guarantor Name: _____ **Date of Birth**: _____

Vision Insurance

Insurance Company: _____ ☐ N/A

Policy Number: _____ **Group Number**: _____

Guarantor Name: _____ **Date of Birth**: _____

Prescription Drug Coverage

Do you have a separate insurance card for prescription drug coverage? ☐ Yes ☐ No

If yes, please attach a copy of the **front and back** of your insurance card(s) to this packet or bring them to your first appointment.

Section 6. Financial Agreement

Financial Policy. MACT Health Board, Inc. "MACT" follows regulations and laws set by Indian Health Services and the State of California. Depending on your status, you will be financially responsible for all, part, or none of the services performed at any of our clinics, as well as any and all costs associated with the collection of services rendered. Proof of eligibility for Medicare, Medi-Cal, and contracted insurance companies is the responsibility of the patient. It is your responsibility to know your insurance plan, covered benefits, and co-pays and deductibles. MACT will submit insurance claims for patients whose insurance is provided by a health plan in which it contracts however; MACT expects same day payment for all co-payments, deductibles, and non-covered services. In cases where patients are required to pay cash for an appointment, a close approximation of the cost must be paid on the day services are rendered. If the actual cost of the treatment amount is different, the difference will be billed or refunded to the patient.

Authorization to Release Information and Assignment of Benefits. MACT has my permission to release information as needed for insurance processing and for my insurance to release payment to MACT Health Board, Inc.

Medicare Authorization: I agree that payment of authorized Medicare benefits be made on my behalf to MACT for any services provided. I authorize any holder of my medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information to

pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and I will be responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible amounts are based upon the charge determination of the Medicare carrier.

Section 6. Emergency Contact Information

Emergency Contact's Name: _____ _____ _____
First Middle Last

Relationship to Patient: _____ **Phone Number**: _____

Section 7. Advance Health Care Directive

MACT Health Board, Inc. is required to offer all new patients who are **eighteen years or older or an emancipated minor** an Advance Health Care Directive however; patients are not required to complete an advance health care directive. Are you interested in receiving an advance health care directive? ☐ Yes ☐ No ☐ I have an advance directive (provide a copy)

Section 8. Pharmacy

Preferred Pharmacy: _____

Phone: _____ **Fax**: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Section 9. Acknowledgements and Authorization

By signing this document, you certify that the information provided throughout this form is true and accurate. Additionally, you indicate receipt, understanding, and acceptance of the following MACT Health Board, Inc. forms and policies:

- Appointment Cancellations and No-Shows
- Financial Agreement
- Notice of Privacy Practices
- Pain Management Agreement
- Patient Rights and Responsibilities
- **For Dental Patients**: Dental Board of California's Dental Materials Fact Sheet

Furthermore, you acknowledge and accept that MACT Health Board, Inc. employs and uses the services of **Non-Physician Medical Practitioners (NMPs)** such as Physicians Assistants and Nurse Practitioners. You may be treated by an NMP.

I/we certify that I/we have read and understand the above information to the best of my/our knowledge. The undersigned patient, and/or responsible party gives permission for MACT Health Board, Inc. to administer healthcare treatment and advice as necessary.

_____	_____	___/___/_____	_____
Print Name of Patient	Signature of Patient	Today's Date	Relationship to Patient
_____	_____	___/___/_____	_____
Print Name of Authorized Representative	Signature of Authorized Representative[1]	Today's Date	Relationship to Patient

[1]If this form is completed and signed by an authorized representative, supporting legal documentation is required.