New Patient Registration (Minor 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. Care, Custody, Control, and Conduct

Do any of the following apply? (Check all that apply. Additional supporting documentation required.)

☐ Adoption	☐ Foster Care	☐ Legal Guardian
☐ Caregiver	☐ Group Home	☐ Legal Name Change
☐ Court Ordered Parental Rights	☐ Guardian ad Litem	☐ Self-sufficient Minor
☐ Emancipated Minor	☐ Kinship Care	☐ Tribal Customary Adoption

Section 4. Patient Information

Patient's Legal Name: ______________________ ______________________ ________________
Last First Middle

Gender Identity: ☐ Male ☐ Female ☐ Other: ________________ **Date of Birth**: ____________________

Social Security Number: ______________________ **Primary Language**: ________________________

Mailing Address: ____

City: ________________________ **State**: _______________ **Zip**: _________

Physical Address: ____

City: ________________________ **State**: _______________ **Zip**: _________

Phone: ____________________ ____________________ ____________________
Home Work Cell

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

Email Address: ________________________ **Employer**: ____________________

American Indian or Alaskan Native Eligibility

____________________ ____________ ________________ ____________
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. Parent or Legal Guardian Information

Primary Parent or Guardian Name: ______________________________________

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

Relationship to Patient:

☐ Parent ☐ County Case Worker ☐ Guardian ad Litem ☐ Social Worker ☐ Other:
☐ Adoptive Parent ☐ Court-ordered Custodial Parent ☐ Legal Guardian ☐ Caregiver ☐ Foster Care Parent

Social Security Number: ________________________ **Primary Language**: __________________________

Physical Address: ____

City: _____________________________________ **State**: _______________________ **Zip**: ______________

Mailing Address: ____

City: _____________________________________ **State**: _______________________ **Zip**: ______________

Phone: _____________________________ ____________________________ _________________________
Home Work Cell

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

Email Address: ____________________________________ **Employer**: ______________________________

Secondary Parent or Guardian Name: ____

Gender Identity: ☐ Male ☐ Female ☐ Other: __________________ **Date of Birth**: ____________________

Relationship to Patient:
☐ Parent ☐ County Case Worker ☐ Guardian ad Litem ☐ Social Worker ☐ Other:
☐ Adoptive Parent ☐ Court-ordered Custodial Parent ☐ Legal Guardian ☐ Caregiver ☐ Foster Care Parent

Social Security Number: ________________________ **Primary Language**: __________________________

Physical Address: ____

City: _____________________________________ **State**: _______________________ **Zip**: ______________

Mailing Address: ____

City: _____________________________________ **State**: _______________________ **Zip**: ______________

Phone: _____________________________ ____________________________ _________________________
Home Work Cell

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

Email Address: ____________________________________ **Employer**: ______________________________

Section 6. Insurance Information

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

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**: _____________________

Section 7. 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, MediCal, 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 noncovered 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 HCFA1500 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 8. Emergency Contact Information

Emergency Contact's Name: _________________________ _______________________ ___________________
Last First Middle

Relationship to Patient: _____________________________ **Phone Number**: ___________________________

Section 9. Pharmacy

MACT Health Board, Inc. "MACT" participates in the 340B Drug Pricing Program which may increase access and convenience to prescription drugs for our patients. Are you interested in changing your pharmacy to a pharmacy that has contracted with MACT for 340B pricing? ☐ Yes ☐ No

Preferred Pharmacy: ____

Phone: ____ **Fax**: ____

Address: __________________________________**City**: ____________________ **State**: ______ **Zip**: ________

Section 10. 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
- **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 MM DD YYYY Relationship to Patient

___________________________ ______________________________ ____/____/_____ ______________________
Print Name of Parent/Authorized Representative Signature of Parent/Authorized Representative[1] MM DD YYYY Relationship to Patient

[1]If this form is completed and signed by a non-custodial parent, including but not limited to a legal guardian, person(s) having legal custody of the minor, or a caregiver of the child who is a relative of the child and who may authorize medical care and dental care under Section 6550 of the California Family Code, supporting legal documentation is required.