HYNDMAN FAMILY HEALTH CENTER
A Division of HAHC, Inc.

144 Fifth Avenue
Hyndman, PA 15545
Phone: 814-842-3206
Fax: 814-310-2008

PATIENT REGISTRATION

DEMOGRAPHICS

LAST NAME	FIRST NAME	MIDDLE	MAIDEN OR SUFFIX
STREET ADDRESS/PO BOX/APARTMENT #	CITY	ZIP AND STATE	DATE OF BIRTH MM/DD/YYYY
HOME PHONE NUMBER ( )	MOBILE PHONE NUMBER ( )	SOCIAL SECURITY NUMBER	SEX AT BIRTH ☐ FEMALE ☐ MALE
EMAIL			
RACE ☐ WHITE ☐ BLACK/AFRICAN AMERICAN ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ ASIAN ☐ CHOOSE NOT TO DISCLOSE ☐ OTHER_____			
ETHNICITY ☐ NOT HISPANIC/LATINO ☐ HISPANIC/LATINO ☐ MEXICAN ☐ CHOOSE NOT TO DISCLOSE ☐ OTHER_____			

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPERATED ☐ WIDOWED	VETERAN ☐ Yes ☐ No	PUBLIC HOUSING ☐ Yes ☐ No	HOMELESS ☐ Yes ☐ No	MIGRANT WORKER ☐ Yes ☐ No	SEASONAL WORKER ☐ Yes ☐ No

EMERGENCY

CONTACT NAME	RELATIONSHIP	HOME PHONE NUMBER ( )	MOBILE PHONE NUMBER ( )
SECOND CONTACT NAME	RELATIONSHIP	HOME PHONE NUMBER ( )	MOBILE PHONE NUMBER ( )

EMPLOYMENT

OCCUPATION	EMPLOYER	EMPLOYER PHONE NUMBER ( )
EMPLOYER STREET ADDRESS/PO BOX	EMPLOYER CITY	EMPLOYER ZIP AND STATE

INSURANCE

RESPONSIBLE PARTY ☐ SELF ☐ OTHER _____	RESPONSIBLE PARTY NAME	RESPONSIBLE PARTY DOB	RESPONSIBLE PARTY SSN

PRIMARY MEDICAL INSURANCE NAME	POLICY NUMBER	GROUP NUMBER
SECONDARY MEDICAL INURANCE NAME	POLICY NUMBER	GROUP NUMBER
PRIMARY DENTAL INSURANCE NAME	POLICY NUMBER	GROUP NUMBER
SECONDARY DENTAL INSURNACE NAME	POLICY NUMBER	GROUP NUMBER
PRESCRIPTION INSURANCE NAME	POLICY NUMBER	GROUP NUMBER

PHARMACY

PHARMACY NAME	PHARMACY TELEPHONE NUMBER ( )

PHARMACY STREET ADDRESS/PO BOX	PHARMACY CITY	PHARMACY ZIP AND STATE

HYNDMAN FAMILY HEALTH CENTER
A Division of HAHC, Inc.

144 Fifth Avenue
Hyndman, PA 15545
Phone: 814-842-3206
Fax: 814-310-2008

PATIENT CONSENTS

CONSENT, ASSIGNMENT, AND RELEASE

I, _____ **(patient name)** _____ **(patient DOB)** give permission for Hyndman Area Health Center, Inc. (HAHC) to provide me with voluntary services. I request that payment of authorized benefits is made on my behalf to HAHC to release protected health information (PHI) to my insurance and its agents to determine benefits or benefits payable for related services. I understand that:

- my health information will be sent to my insurance company;
- I must pay my share of the costs when I receive my services;
- I must pay for the cost of services if I do not have insurance, or it does not pay after 90 days;
- I have the right to refuse any procedure or treatment and that all services are voluntary; and
- I may request a copy of HAHC Notice of Privacy Practice or Bill of Rights at any time.

PATIENT CONSENT TO EXTERNAL PRESCRIPTION HISTORY

I allow HAHC to view my external prescription history via electronic health record system. This will allow HAHC to have the information needed regarding medications I am taking in order to minimize adverse drug reactions. By accepting this consent, I understand that my prescription history from multiple healthcare providers, insurance companies, and pharmacies may be viewed by authorized staff of HAHC, and it may include prescriptions back in time for several years. I understand that I may revoke this consent at any time in writing but if I do, it will not influence my treatment. I understand that HAHC can request and use my prescription medication history from other healthcare providers, insurance companies, and pharmacies.

***If you wish to opt-out of external prescription history please inform the front desk or your provider.**

ELECTRONIC HEALTH RECORDS OPT-IN

HAHC is working together with other healthcare providers to deliver integrated electronic health records to enable the sharing of your PHI between healthcare professionals to help in the transformation of healthcare services. Sharing health information is secure and available only for permitted users between HAHC, Inc. and other healthcare providers. Integrating electronic health records will enable healthcare professionals who are directly involved in my healthcare to provide me with the best possible care. The primary benefits of having an integrated electronic health record include:

- avoidance of duplicated investigations or repeating the same information to different providers;
- providers have an increased awareness of key patient information;
- reduced hospital visits as providers will have awareness of pre-existing conditions and care; and
- making the process quicker and easier.

HAHC protects the privacy and security of my information. We use different security controls to keep your information confidential. The information is available for viewing and for use by authorized HAHC employees only. All federal and state privacy laws will be followed. The federal Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH), and related regulations, set standards for this.

***If you wish to opt-out of electronic health records please inform the front desk or your provider.**

_____ _____
Patient Signature Date

_____ _____
Parent or Legal Guardian Name & Signature Date

HYNDMAN FAMILY HEALTH CENTER
A Division of HAHC, Inc.

144 Fifth Avenue
Hyndman, PA 15545
Phone: 814-842-3206
Fax: 814-310-2008

SLIDING FEE DISCOUNT PROGRAM

PATIENT NAME	DATE OF BIRTH MM/DD/YYYY	DATE

Hyndman Area Health Center, Inc. (HAHC) offers a sliding fee scale to patients based on their income and family size. To see if you qualify, please complete the following, which is based off the 2025 federal poverty guidelines. If you qualify, a Patient Service Representative will have you complete the Sliding Fee Scale Application as the next step. **Proof of household income will be required.**

Please ***circle*** your family size with your combined estimated annual household income:

Family Size: 1	$15,650.00	$15,806.50	$19,719.00	$23,631.50	$27,544.00	$31,456.50
Family Size: 2	$21,150.00	$21,361.50	$26,649.00	$31,936.50	$37,224.00	$42,511.50
Family Size: 3	$26,650.00	$26,916.50	$33,579.00	$40,241.50	$46,904.00	$53,566.50
Family Size: 4	$32,150.00	$32,471.50	$40,509.00	$48,546.50	$56,584.00	$64,621.50
Family Size: 5	$37,650.00	$38,026.50	$47,439.00	$56,851.50	$66,264.00	$75,676.50
Family Size: 6	$43,150.00	$43,581.50	$54,369.00	$65,156.50	$75,944.00	$86,731.50
Family Size: 7	$48,650.00	$49,136.50	$61,299.00	$73,461.50	$85,624.00	$97,786.50
Family Size: 8	$54,150.00	$54,691.50	$68,229.00	$81,766.50	$95,304.00	$108,841.50

For each additional household member above family size of 8 add $5,500

ALERTS AND NOTIFICATIONS

HAHC strives to enable patients to take part in achieving their health care goals. Through our automated voice, text, and email messaging system we will keep you informed of upcoming appointments and send you friendly reminders. If you provided your email, you will have access to our Patient Portal where you can access your health history, see upcoming appointments, test results, and much more. Please select your preferences below.

1. I would like to receive alerts and notifications by: (check all that apply)
   - □ Voice
   - □ Text

2. When would you like to receive alerts and notifications? (check one)
   - □ Morning
   - □ Afternoon
   - □ Evening

3. Type of alerts and notifications I would like to receive: (check all that apply)
   - □ Appointment Reminders
   - □ Lab Results
   - □ Health Maintenance
   - □ Rx Confirmations
   - □ General Notification
   - □ Healow Prime+ Notification

HYNDMAN FAMILY HEALTH CENTER
A Division of HAHC, Inc.

144 Fifth Avenue
Hyndman, PA 15545
Phone: 814-842-3206
Fax: 814-310-2008

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

PATIENT NAME	DATE OF BIRTH MM/DD/YYYY	DATE

MESSAGE AUTHORIZATION

May we leave a message on your: (may choose more than one)			
Home Phone	□ Yes □ No	□ Detailed □ Brief □ Ask for Return Call Only	( )
Cell Phone	□ Yes □ No	□ Detailed □ Brief □ Ask for Return Call Only	( )
Employer Phone	□ Yes □ No	□ Detailed □ Brief □ Ask for Return Call Only	( )

REQUEST FOR SPECIAL PERMISSION

I understand that Hyndman Area Health Center, Inc. (HAHC) may use or disclose my protected health information (PHI) for the purpose of treatment, payment and healthcare operations. HAHC may also disclose information to someone involved in my care or the payment of my care, such as a family member or friend.

I hereby permit HAHC to disclose PHI to the following people:

Name	Relationship to Patient

□ DO NOT disclose PHI to anyone

Comments or Special Instructions:

_____ _____
Patient Signature Date

_____ _____
Parent or Legal Guardian Name & Signature Date