THE HEALTH HUT
A COMMUNITY HEALTHCARE IN MOTION PROJECT

REGISTRATION FORM

Name: _____
FIRST MIDDLE INITIAL LAST

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home (_____) _____ Work (_____) _____ Cell (_____) _____

Date of Birth: _____/_____/_____ Social Security #: _____-____-_____ Gender: _____

Marital Status: ☐ Single ☐ Married ☐ Other Email: _____

Do you consider yourself to be Hispanic or Latino (a person of Mexican, Puerto Rican, Cuban, Central American, South American, or other Spanish culture or origin, regardless of race)? ☐ Yes ☐ No

Race (Check one or more boxes.):
☐ White/Caucasian ☐ Black or African American ☐ North, South, or Central American Indian or Alaska Native
☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Other: _____

Primary language: ☐ English ☐ Spanish ☐ Other: _____ Do you require a translator? ☐ Yes ☐ No

Are you employed? ☐ Yes ☐ No ☐ Retired Name of Employer: _____

Are you a student: ☐ Yes ☐ No Name of School: _____

Do you have any health insurance? ☐ Yes ☐ No **PLEASE GIVE CARD TO RECEPTIONIST.**

Person to contact in case of emergency: _____

Phone: (_____) _____ Relationship to you: _____

Who is it okay to discuss your health with?

- ☐ No one
- ☐ _____ Relationship _____ Phone No. _____
- ☐ _____ Relationship _____ Phone No. _____

Signature of patient or legal representative: _____ **Date:** _____

If signed by legal representative, relationship to patient: _____

THE HEALTH HUT
310 W. Mississippi Ave.
Ruston, LA 71270
Phone: 318-513-1212
Fax: 318-513-7673

Print Patient Name: _____

General Consent for Treatment

1. I give permission for The Health Hut to give me medical treatment.
2. I allow The Health Hut to file for insurance benefits to pay for the care I receive. I understand that The Health Hut will have to send my medical record information to my insurance company.
3. I understand:
    - I have the right to refuse any procedure or treatment.
    - I have the right to discuss all medical treatments with my clinician.

_____ _____
Signature of Patient or Personal Representative Authorized by Law Date

_____
Relationship (if Signature is not of Patient)

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that The Health Hut has provided me with a copy of its Notice of Privacy Practices. I understand the Notice describes The Health Hut's privacy practices regarding the use and/or disclosure of patient health information.

_____ _____
Signature of Patient or Personal Representative Authorized by Law Date

_____
Relationship (if Signature is not of Patient)

Signature of THH Staff Member: _____ _____
Date

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency prevented us from obtaining acknowledgement
- □ Other (*Please specify*)

_____