



SMART Registration

For Office Use Only
Location:
Account #:
Date:

Patient Information *(Please Print)*

Child's Name Last	First	MI	Social Security #	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age	Birth Date
My child participates in the School's free and reduced lunch program? <input type="checkbox"/> Yes <input type="checkbox"/> No (you are not required to answer this question)						
Race <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Native Alaskan <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> American Indian <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other _____			Homeless Status <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Transitional <input type="checkbox"/> Doubling Up <input type="checkbox"/> Street <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____			
Home Address		City/State/Zip Code		County		Home Phone # ()
Mailing Address		City/State/Zip Code		Work Phone # ()		
Child's School						Alternate Phone # ()
Full Name of Mother			Social Security #	Birth Date	Home Phone # ()	
Home Address		City/State/Zip Code		Employer		Work or Alternate Phone # ()
Full Name of Father			Social Security #	Birth Date	Home Phone # ()	
Home Address		City/State/Zip Code		Employer		Work or Alternate Phone # ()
Legal Guardian (if applicable)			Relationship to Patient		Home Phone # ()	
Home Address		City/State/Zip Code		Work or Alternate Phone # ()		

Contact Information

By signing below, I authorize Cherokee Health Systems to release information concerning my minor child, or legal charge as indicated. I understand that I may revoke this consent to release confidential information at any time. Unless I revoke this authorization, this authorization shall remain in effect for one (1) year.

Emergency Contact Name/Relationship	Contact Address	City/State/Zip Code	Contact Phone # ()
Information to Release to Contact <input type="checkbox"/> Appointment <input type="checkbox"/> Financial/Billing <input type="checkbox"/> Pharmacy Pick-up <input type="checkbox"/> Emergency Information			
Signature X _____ Date _____			
Contact Name/Relationship	Contact Address	City/State/Zip Code	Contact Phone # ()
Information to Release to Contact Please check all that apply below <input type="checkbox"/> Appointment <input type="checkbox"/> Financial/Billing <input type="checkbox"/> Pharmacy Pick-up			
Signature X _____ Date _____			

Statement of Privacy Practices

I have received Cherokee Health System's *Statement of Privacy Practices*.

Parent's signature (or legal guardian's, if applicable) **X** _____ Date _____

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I provided CHS's *Statement of Privacy Practices* to (Child's Name) _____.

CHS Staff Signature _____ Date _____

Insurance Information				
<i>(Please bring a copy of your insurance card to the nurse.)</i>				
Person Responsible for Payment		Mailing Address		City/State/Zip Code
Employer		Employer's Address		City/State/Zip Code Employer Phone # ()
Primary Insurance Company		Claims Mailing Address		City/State/Zip Code
Phone # ()	Effective Date	Group #	ID #	Who is coverage through? <input type="checkbox"/> Self <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other
Secondary Insurance Company		Claims Mailing Address		City/State/Zip Code
Phone # ()	Effective Date	Group #	ID #	Who is coverage through? <input type="checkbox"/> Self <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other

Insurance Authorization

There are fees for all services provided by Cherokee Health Systems (CHS.) It is expected that patients pay on the day they are seen. Health insurance policies may cover a portion of the fees and CHS staff will assist you in making claims. It is expected that you will inform us of changes in your financial status or health insurance coverage. Please read the *Authorization for Insurance Billing/Release of Information* section below, fill in the name of your insurance company(s), and sign. If uninsured and requesting a discount for services provided, please read below.

Authorization for Insurance Billing/Release of Information

By signing below, I authorize Cherokee Health Systems to assist me in obtaining third party benefits, to file benefit claims on my behalf, and to release any information necessary for the processing of my claim(s) to: *Name of Insurance Company, or Other Third Party Benefit Agent(s)*

I understand that such information may include diagnosis, dates of service, types of treatment, results of evaluations/assessments, actual progress notes, and other information about services received. This release shall remain in effect until all claims filed on my behalf have been processed.

I authorize and request direct payment of my health insurance benefits to Cherokee Health Systems. This authorization shall apply to all covered health services that I receive at the School Clinic. If requested, I have been provided with a copy of the fee scale.

Parent's signature (or legal guardian's, if applicable) **X** _____ Date _____

Witness _____ Date _____

If Uninsured and Would Like to Apply for a Discount

If you do not have health insurance benefits, you may apply for a discount by providing written proof of your total household income. Income may include: salary or wages, SSI, Social Security, retirement, disability payments, veteran's benefits, Black Lung benefits, alimony, child support, and interest income. You may use paycheck stubs for at least three consecutive pay periods, benefits check stubs, W-2 forms, a copy of your most recent federal tax forms, or a copy of applications for any other agency benefits if they include household income (i.e., applications at DHS, Helping Hands applications or cards, etc.). Once you supply the required documentation (pay stubs, W-2 forms, etc.), the application will be reviewed to determine your eligibility for the discount. If you have questions, please call our CHS Telemedicine Department at 865.225.2110.

The discount is based on the total number of people and income in your household. Please complete the following:

Name	Age	Relationship	Monthly Income
Total			

I certify that the information and documentation I have provided is accurate. I know that my application information will need to be updated periodically as changes occur. I will pay my fees at the time of service unless I have made other payment arrangements with CHS.

Parent's signature (or legal guardian's, if applicable) **X** _____ Date _____