COMMUNITY
HEALTH CENTER
Of The New River Valley

Welcome to your Health Care Home!

Thank you for choosing our Community Health Center as your Health Care Home. As your Health Care Home, you will be asked to select a primary provider, who will oversee all of the care you receive. That provider is assisted by a care team made up of nurses and other support staff. Your care team will coordinate your health care throughout all settings inside and outside of our Community Health Center to promote better health for you, our patient.

We provide the highest quality of health care, based upon current medical, dental, and behavioral health research, standards, and protocols. We provide integrated care so that all of your providers work together to provide comprehensive and holistic care that considers every aspect of your health. We will involve you in the decisions made on your behalf.

As a Health Care Home, we function best when we have your complete medical history and information about health care obtained by other providers outside of this Health Center. We will always ask you for updates about other medical, dental, and mental health care you have received, so we can stay up to date and provide the most appropriate and continuous service possible.

Also as a Health Care Home, we provide timely clinical advice on the telephone and via a secure web-based Patient Portal, both during office hours and when the office is closed. Instructions for obtaining care and clinical advice using the telephone and Internet are included in this welcome packet.

At our Center, no one is denied service due to an inability to pay. Persons with limited income may qualify for our Sliding Fee Scale. Please inquire.

Montgomery Center
215 Roanoke Street, Christiansburg, VA 24073
Ph: 540-381-0820
Hours: 8:00—5:00 Monday-Friday
Also 5:00—7:00 pm Thursday evenings

Giles Center
219 Buchanan Street, Pearisburg, VA 24134
Ph: 540-921-3502
Hours: 8:00—4:30 Monday-Friday

Pulaski/Radford Center
5826 Ruebush Road, Dublin, VA 24084
Ph: 540-585-1310
Hours: 8:30—5:00 Monday-Friday

After-Hours Call Service for All Sites:
540-251-0250

We provide the following services to people of all ages:

- Primary Health Care
- Check-ups, Preventive Care
- Chronic Disease Management
- Care Coordination and Referrals
- Well Child Visits, Vaccinations
- Behavioral Health Services
- Medication Assistance
- General Dentistry, including extractions, cleaning, fillings, crowns, bridges, and dentures
- Insurance Assistance, with the Federal Health Insurance Marketplace, Medicare, Medicaid, and FAMIS

A Language Line is available for patients who need translators.

The mission of the Community Health Center of the New River Valley is to provide affordable and high quality medical, dental, behavioral and preventive health services to people of all ages and circumstances, regardless of ability to pay.

Community Health Center of the New River Valley

Patient Registration Form

First Name:_____

Last Name:_____

Date of Birth:_____

Social Security #: _____

Address:_____

City:_____

State & Zip Code:_____

Email Address: _____

Home Phone:_____

Cell Phone:_____

Work Phone:_____

Preferred Method of Contact (circle):

Home Phone Cell Phone Text Message Email

Occupation: _____

Sex: Male Female Other

Sexual Orientation (circle):

Straight (not lesbian or gay) Lesbian/Gay Bisexual

Something Else Don't Know Choose not to disclose

Gender Identity (circle): Male Female

Transgender Male/Female-to-Male Other

Transgender Female/Male-to-Female Choose not to disclose

Marital Status:_____

Are you a (circle one):

U.S. Citizen U.S. Resident Other

Are you a United States Veteran? Yes No

What is your primary language? _____

Do you require an interpreter? Yes No

Race (select all that apply):

____African-American ____Native American

____Asian ____Pacific Islander

____Caucasian ____Other

Ethnicity (select one):

____Hispanic ____Non-Hispanic

Phone Contact Permission:

List person/persons whom the Center (CHCNRV) may contact in the event we are not able to speak to you or in the event of an emergency.

Name:_____

Relationship to Patient: _____

Phone:_____

Name:_____

Relationship to Patient: _____

Phone:_____

Billing Information: It is important that you provide us with complete and accurate information (i.e. home address, phone numbers) so that we may properly submit billing data to your insurance company. We will make every effort to submit claims to your insurance company and promptly provide you with our statements. However, if for any reason the statement is returned to our office because of a problem with an address you provided, we will call you to secure full payment. Please ensure that all of your information is accurate and up-to-date. Please be sure to bring your photo identification and your insurance cards to every visit so that we may properly bill your insurance company. If you do not have your insurance card with you, you may be required to make payment in full that day.

Primary Insurance Company Information

Company:_____

Subscriber/Policy/Medicare/Medicaid Number:_____

Group Number:_____

Primary Policy Holder Information

Policy Holder Name:_____

Policy Holder DOB:_____

Relationship to Patient:_____

No Insurance Coverage:

I currently do not have any medical insurance or pharmacy prescription coverage, whether through the government (Medicare or Medicaid), employment, or a private company. When I receive insurance coverage or pharmacy prescription coverage, I will notify the Community Health Center within 30 days of the start date of the new insurance and will provide a copy of my card.

Initial here: _____

By signing below, I am acknowledging that the above information is true and accurate to the best of my knowledge. I have had the opportunity to review the Notice of Privacy Practices and the No-Show Policy. I also attest that if it is found that I am knowingly withholding insurance information and the time frame to file previous claims has been exceeded, I will be held responsible for any past due amounts.

Signature of Patient or Legal Guardian: _____ Date:_____

Community Health Center of the New River Valley

Health History Form

Name: _____ Nickname: _____ Date of Birth: _____
First Middle Last

Name of Pharmacy: _____ Phone number: _____

GENERAL HEALTH

Why did you make this appointment? (Check all that apply.)

☐ Regular checkup
☐ First appointment to start care with a new doctor
☐ Switching doctors (from whom: _____)
☐ Have a specific health problem (if so, explain _____)

Are you taking any prescription medicines?

☐ Yes. Please list your medicines below. ☐ No, I do not take any prescription medicines.

Name of Medicine	Amount /Size of Pill	How many pills or doses do you take at
		___morning ___noon ___dinner ___bed
		___morning ___noon ___dinner ___bed
		___morning ___noon ___dinner ___bed
		___morning ___noon ___dinner ___bed

(Please use the back of this form if you have more prescription medicines.)

What over-the-counter medicines (medicine you do not need a prescription for), do you take regularly?

☐ Pain reliever (example: Tylenol, Advil, aspirin) ☐ Antacid (example: Tums, Prilosec)
☐ Vitamins ☐ Herbal medicine (Fish oil, Ginseng) (list)_____
☐ Other (please list) _____
☐ None - I do not take any over-the-counter medicines regularly.

Do you get an allergic reaction (bad effect) from any of the following? (Check all that apply)

☐ latex (rubber gloves) ☐ grass or pollen ☐ eggs ☐ shellfish
☐ Other (please describe) _____
☐ No - I have no allergies that I know of.

Have you ever had any allergic reaction (bad effects) to a medicine or a shot?

☐ Yes. (Please write the name of the medicine and the effect you had.) ☐ No, I am not allergic to any medicines.

Medicine I am allergic to	What happens when I take that medicine

Have you ever been a patient in a hospital overnight?

☐ Yes. (If yes, explain EACH reason and when.) ☐ No, I have never been

I was in the hospital because:	When

Have you ever had a colonoscopy (a test to look at your insides by sending a camera through your bottom)?

☐ Yes ☐No When:_____ Where:_____

Community Health Center of the New River Valley

Health History Form

SHOTS

When was your last **Tetanus shot**? Year_____ ☐never ☐ don't know

When was your last **Pneumonia shot**? Year_____ ☐never ☐ don't know

When was your last **Flu shot**? Year_____ ☐never ☐ don't know

SOCIAL HISTORY

Do you smoke cigarettes, cigars, use snuff, chew tobacco, or vape?

☐ No (if no, go to next question)

☐ Yes a. When did you start?_____

b. How much per week? _____

c. Have you quit? ☐ No ☐ Yes, when_____

d. Do you want to quit? ☐ No ☐Yes ☐ Already Quit

Do you drink alcohol?

☐ No (if no, go to next question)

☐ Yes - How many drinks do you typically drink in a week? _____ drinks

a. Have you ever felt you should cut down on your drinking? ☐ Yes ☐No

b. Have you ever felt bad or guilty about your drinking? ☐ Yes ☐No

c. Have you ever had a drink first thing in the morning? ☐ Yes ☐No

Do you Exercise? ☐ No ☐Yes If yes, what do you do? _____

Check any of the following things you use to help you walk.

☐ Cane ☐ Walker ☐ Wheelchair ☐ I do not need any help walking

Check any of the following types of help at home you receive (paid help or family and friends).

☐ Cleaning/laundry ☐ Shopping ☐ Personal Care ☐ Taking medications ☐ None

In the past year, do you feel that you have been emotionally or physically abused? ☐ Yes ☐No

HISTORY OF MEDICAL CONDITIONS

Have you **ever** had any of the following conditions? (Check all that apply)

☐ Anemia (low iron blood) ☐ Asthma (wheezing) ☐ Diabetes (sugar)

☐ Heart Trouble ☐ Hemorrhoids (piles) ☐ Cancer

☐ Hepatitis (yellow jaundice) ☐ Tuberculosis (TB) ☐ Pneumonia

☐ Rheumatic fever ☐ Ulcers ☐ Stroke

☐ High Blood Pressure ☐ Skin problems ☐ Depression (feeling down or blue)

☐ Epilepsy (fits, seizures) ☐ Anxiety (nerves, panic attacks)

☐ STD (gonorrhea, HIV) ☐ Other_____

Community Health Center of the New River Valley

Health History Form

FOR WOMEN ONLY

Have you ever been or currently pregnant? ☐ Yes - How many times?_____ ☐No

How many children have you given birth to?_____

Do you use birth control? (the pill, condoms, intra-uterine device, Nexplanon) ☐ Yes ☐No

If yes, which kind? _____

Have you had a PAP smear? ☐ Yes ☐No

Date of last one _____Where: _____

Have you ever had a PAP smear that was not normal? ☐ Yes ☐No

Have you had a mammogram (breast x-ray)? ☐ Yes ☐No

Date of last one_____Where: _____

RELEASE OF INFORMATION

List any person who we can talk to about your medical conditions (Protected Health Information) and your appointments. This *excludes Behavioral Health and Substance Abuse conditions (Protected Health Information),* a separate release of information will need to be signed to discuss these with other individuals.

Name	Phone Number	Relationship

By signing below, I agree that I have provided true answers to the best of my knowledge. It is my responsibility, as the patient, to contact previous physician's offices for transfer of medical records. I have the ability to ask for a copy of my medical records at any time from CHCNRV.
I have reviewed the Notice of Privacy Practices (HIPAA).

Signature of Patient or Legal Guardian: _____ Date:_____

Dental Health History

Patient's Name:_____ Date:_____

Birthdate: ____/____/____ Age: ____ Sex (circle one): Male or Female

When was your last dental visit? _____

What was the reason for your last visit?

_____

Do you brush daily? YES or NO times per day:_____

Do you floss daily? YES or NO times per day:_____

Do you have a specific dental problem or concern?

_____

_____

_____

_____

How would you rate your current dental health? ☐ Good ☐ Fair ☐ Poor

Are you currently in discomfort? YES or NO

Have you been to the ER in the last year for dental issues? YES or NO

If yes, when and where did you go?

_____

Have you gone to the ER several times for the same problem? YES or NO

If yes, how many times? _____

Do you have Osteoporosis? YES or NO

Do you have a history of taking Bisphosphonates? (Bisphosphonates are prescription drugs that are commonly used to treat Osteoporosis, like Boniva or Fosamax) YES or NO

Do you require antibiotic pre-medication prior to dental work? YES or NO

Do you have tooth sensitivity to:

☐ heat ☐ cold ☐ sweet ☐ discomfort when biting

☐ recurring sores or blisters in/on your mouth, tongue, lips, etc.

GENERAL DENTISTRY INFORMED CONSENT FORM

COMMUNITY HEALTH CENTER of The New River Valley

1. **EXAMINATION AND X-RAYS**
   I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.

2. **DRUG, MEDICATION, AND SEDATION**
   I have been informed and understand that antibiotics, analgesics, and other medications can cause allergic reactions, causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased using alcohol or other drugs. I understand that and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infections, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives, i.e. birth control.

3. **CHANGES IN TREATMENT PLAN**
   I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions as necessary.

4. **FILLINGS**
   I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage, and tooth sensitivity is a common after-effect of a newly placed filing.

5. **REMOVAL OF TEETH (EXTRACTION)**
   Alternative to removal has been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for the reasons in paragraph #3. I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, and spread of infection; dry socket; loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) that can last for an indefinite period of time; or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

6. **CROWNS, BRIDGES, VENEERS AND BONDING**
   I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crowns, bridge or cap (including shape, fit, size, placement, and color) will be done before cementation. It has been explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

7. **DENTURES—COMPLETE OR PARTIAL**
   I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including, shape, fit, size, placement, and color" will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not the initial denture fee.

8. **ENDODONTIC TREATMENT (ROOT CANAL)**
   I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

9. **PERIODONTAL TREATMENT**
   I Understand that I have a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, follow a healthy a healthy diet, avoid tobacco ad follow other recommendations.

10. **TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ)**
    I understand that symptoms of popping, clicking, locking, and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost is my responsibility.

CONSENT: *I understand that dentistry is not an exact science; therefore, reputable providers cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorize. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist is responsible for my dental treatment.*

Signature: _____ Date: _____

Community Health Center of the New River Valley

Acknowledgments and Authorizations Form

Patient Name_____ **SS#**_____ **Birthdate**_____

Sign your initials next to each section:

_____**CONSENT FOR TREATMENT:** I authorize the employees, agents and staff of the Community Health Center to perform and hereby consent to such medical treatment and examinations, including diagnostic procedures or behavioral health evaluations, as may in the opinion of the patient's physician be necessary.

_____**NO GUARANTEE:** I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of any procedures, treatments or examinations.

_____**FINANCIAL RESPONSIBILITY:** I understand that I am financially responsible for all charges, whether or not paid by insurance. The Community Health Center does not participate in **EVERY** insurance plan. I understand that I am responsible for verifying that the Community Health Center provider is a participating provider in my insurance plan. Payment is expected at the time of service.

_____**RELEASE OF INFORMATION:** I authorize the center to release any and all patient medical and billing information to any physician involved in my treatment; to any healthcare facility to which I/the patient is discharged or transferred to for treatment, billing, quality assurance, collection, or defense of litigation or anticipated litigation; and to any insurance company, review organization or other entity, which is directly or indirectly responsible for payment or review of services provided by the Community Health Center. I consent to the use and/or disclosure of my protected health information to carry out treatment, payment or healthcare operations by the Community Health Center.

_____**DEEMED CONSENT FOR BLOOD TESTING:** I understand that under Virginia Law, if a healthcare provider, a person employed by, under the direction of, or control of a healthcare provider, is directly exposed to body fluids of a patient, which may transmit viruses causing HIV or Hepatitis B or C, the patient will be deemed to have consent for testing for HIV or Hepatitis B or C, and to the release of such test results to the person who was exposed. (Exposure could occur due to an accidental needle stick.) A patient who tests positive will be afforded the opportunity for individual face-to-face disclosure of test results and appropriate counseling.

_____**SLIDING FEE SCALE:** Qualifying for our sliding fee scale based on your family income and family size may result in lower charges. You are required to report any income and family size changes to us as this may impact the amount you are expected to pay. We will review and update your information annually. Eligibility cannot be determined until we receive all requested information. **If it is determined you are not eligible for a sliding fee and you have incurred charges, you will be expected to pay the balance due.** We will assist you by arranging a payment plan if needed. You will be asked to pay a minimum fee for your first visit until the sliding fee eligibility process is complete. The remaining cost of the first and subsequent visits will be based on the outcome of this determination. If you do not pay for services at the time they are rendered, your balance must be paid in full within ninety (90) days.

_____**MEDICARE LIFE-TIME/MEDICAID SIGNATURE AUTHORIZATION AND ASSIGNMENT:** I request that payment of authorized Medicare/Medicaid benefits be made on my/the patient's behalf of any services furnished by or in the center, including physician services. I authorize any holder of medical or other information about me, to release to the Community Health Center for Medicare and Medicaid services, the Virginia Department of Medical Assistance Services and their agents, any information needed to determine these benefits or benefits for related services. I assign the benefits payable for physician and other medical services claims to Medicare and/or Medicaid for payment. I understand that I/the patient am responsible for any deductibles, co-payments and any applicable percentage of remaining charges.

_____**CERTIFICATION AND ACKNOWLEDGEMENT:** I certify that all of the above information and all information supplied by me, as part of the registration process, is correct. I also acknowledge receipt of the Community Health Center's Notice of Privacy Practices (HIPAA).

_____ _____

Patient or Parent/Legal Guardian Date

_____ _____

Relationship to Patient Witness Signature

Informed Consent for Integrated Care Services

I hereby agree to Integrated Care services through the Community Health Center of the New River Valley.

I understand that my physician/nurse practitioner may make a referral to behavioral health services and discuss my medical care and behavioral health concerns with the Integrated Treatment Care Coordinator when necessary. I understand that my physician/nurse practitioner will ask for my permission before conducting the consultation/referral process and will inform me about what was discussed if I am not able to meet with the Integrated Treatment Care Coordinator on the day the referral was made. I understand that beginning any counseling or psychiatric services is my choice and initiation of services will be discussed directly with me by the Integrated Treatment Care Coordinator.

I understand that all information regarding services is confidential and will not be released to any other agency or individual without my knowledge and consent, except when required by law (such as abuse and/or neglect of a person who is presently a minor or elderly, and/or serious intent of harm to self or others).

I have been given a full explanation of Integrated Care Services at the Community Health Center and I agree to the guidelines stated in this document.

_____

Name of Patient or Legal Guardian (Please Print)

_____ _____

Signature of Patient or Legal Guardian Date

Application for Sliding Fee Discount Program

Welcome to the Community Health Center of the New River Valley. We offer affordable health care and dental care through the use of a Sliding Scale Fee to all patients at or below 200% of the poverty level. All patients are eligible to apply for the sliding fee scale.

If you want to apply for the sliding fee discount program, you must meet with a Patient Services Representative (PSR) who will review your patient packet and sliding fee application. At this time, the PSR can answer any questions you may have regarding the Sliding Fee Discount Program and how it works.

If you are applying for the sliding fee scale, please complete the attached Household Financial Information Form. You are required to bring proof of ALL income that is received in your household, your most recent taxes filed (if you filed taxes), and proof of identification.

Examples of Income:

- Paycheck stubs for most recent full month of work.
- A copy of your Disability Determination letter.
- A copy of your Unemployment or Workers Compensation letter.
- A copy of your benefit letter from the Social Security Administration or other retirement fund.
- Documentation of any child support or alimony payment received.
- Documentation of income from any other source.
- Bank Statement showing income deposits and from what source.
- If you have no income, we ask for a Letter of Support signed by the person who provides you with basic necessitates.
- All other forms of income.

Examples of Tax Documents:

- Federal Income Tax Return (1040, 1040EZ) and W-2 for the most recent filing year.
- 4506-T - If your family did not file federal income tax, we will provide you with a form verifying non-filing.

Examples of Identification Documents:

- Your driver's license or other photo ID. (Passport, student ID, Resident Green Card, etc.)
- Your insurance card, if you have insurance.

Our Patient Services Representatives are available to meet Monday-Friday.
All appointments are done on a walk-in basis.

Community Health Center of the New River Valley

Household Financial Information Form

How many people are in your family? _____
Please list them below, with the required information for each.

Family Members: (include yourself)	SSN:	Date of Birth:	Relation	Monthly Gross Income*	Employer Name (If employed)

***If someone can claim you as a dependent on their taxes, then list all other family members on that tax return.**

Document and provide proof of all income received: Paycheck stubs, Retirement, Social Security, Pension, Disability, Worker's Compensation, Unemployment, Child Support, and ALL others not listed. **Application will be rejected if documentation is not provided.**

Employment Information

Employer Information	Income Information
Employer: _____ Date Employment Began: _____ Employer Phone: _____ Circle One: Full-Time Part-Time	How often are you paid? _____ Amount you are paid: _____
Unemployment Information	**Disability Information**
If Unemployed, date employment ended: _____ Does anyone receive unemployment wages? If yes, how much? _____	If Unemployed, has anyone applied for Disability? Yes / No Is anyone in your family planning on applying for disability? This includes you. Yes / No

Government Assistance Information	Personal Information
Medicaid? Yes / No Who? _____ Do you/spouse or any children under 18 receive Social Security Benefits? Yes / No	Child Support received: _____ Alimony received: _____ Did your household file income taxes last year? Yes / No Joint or Single? Circle One.
Insurance Information	
Do you or others in the family have insurance? Yes / No	

The information provided is, to the best of my knowledge and belief, accurate and true. I authorize the release of all information which the Community Health Center may need to determine whether I qualify for financial assistance through their Sliding Fee Discount Program.

Signature of Patient or Legal Guardian: _____ Date: _____