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 Discount Fee Program. 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:
804-729-5122

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: _____

Parent/Legal Guardian: _____

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

How did you hear about us: _____

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
____White ____ Hispanic
____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: _____

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: _____

Policy Holder Address: _____

_____

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)

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

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:_____

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

If the patient is a minor, are they up to date on their vaccinations? ☐ Yes ☐ No
If yes, please **provide a copy of the minor's immunization record**. If no, please explain why?

_____

SOCIAL HISTORY

Do you smoke cigarettes, cigars, use snuff, chew tobacco, or vape?
☐ No (if no, go to next question)
☐ Yes, When did you start?_____How much per week? _____

Do you drink alcohol?
☐ No (if no, go to next question)
☐ Yes - How many drinks do you typically drink in a week? _____ drinks

Do you use anything to help you walk? ☐ Yes ☐ No If yes, what? _____

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_____

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: _____

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.

_____**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.

_____**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.

_____**FINANCIAL RESPONSIBILITY/MEDICARE/MEDICAID:** 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. Patients' are responsible for understanding benefits. Payment is expected at the time of service. I understand that I/the patient am responsible for any deductibles, co-payments and any applicable percentage of remaining charges.

_____**DISCOUNT FEE PROGRAM:** Qualifying for our discount fee program 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 the discount fee program 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.

_____**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 understand that my provider works within a multi-disciplinary team, collaborating with social workers, care coordinators, and case managers as appropriate in order to ensure that my health care needs are most appropriately met.

I understand that my integrated care team will regularly discuss my care and all team members have access to my protected health information (PHI) including, but not limited to, behavioral health/substance use disorder diagnoses and progress notes.

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).

For additional questions regarding Integrated Care at the Center, please request additional information from a member of your health care team.

_____

Name of Patient or Legal Guardian (Please Print)

_____ _____

Signature of Patient or Legal Guardian Date

Community Health Center of the New River Valley

HIPAA

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 (Sensitive 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 provider'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: _____

Consent for Minor and/or Adult with Guardian

Consent for treatment when Parent/Legal Guardian is not physically with Minor/Adult with Guardian

Name of Minor/Adult with Guardian: _____ **DOB**: _____

I (we) appoint _____ and/or _____ who is the
(Proxy Decision Maker Name) (Proxy Decision Maker Name)

patient's _____ /_____ as my (our) proxy
(Relationship to Minor/Adult with Guardian) (Relationship to Minor/Adult with Guardian)

decision maker for consenting to nonurgent medical care for my (our) minor/adult with guardian listed above. I (we) have the legal right to delegate such consent to the proxy decision maker, who is an adult and legally and medically competent to exercise the authority so delegated. Be advised that protected health information may be shared with the proxy to facilitate informed decision making.

IN WITNESS WHEREOF, the undersigned have executed this instrument as the _____ day of _____, 20____.

(Date good for one year from date of paperwork unless revoked in writing)

_____ _____
Parent or Legal Guardian Name Parent or Legal Guardian Signature

_____
Driver's License Number of Proxy Decision Maker

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.

Application for Discount Fee 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 Discount Fee Program to all patients at or below 200% of the poverty level. All patients are eligible to apply for the discount fee program.

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

If you are applying for the discount fee program, please complete the attached Household Financial Information Form.

You are required to bring proof of identification and ALL income that is received in your household.

Examples of Income:

- Paycheck stubs for most recent full month of work
- Bank Statement showing income deposits
- Social Security Letter
- SNAP/WIC Benefits Letter
- Self -Employment Documentation (Taxes are Recommended)
- Letter from Employer
- Retirement/Pension
- If you have no income, we ask for a Letter of Support signed by the person who provides you with basic necessities
- Documentation of income from any other source

Our Patient Services Representatives are available:

Montgomery Center: Monday - Friday, from 8:30am to 4:30pm.
Pulaski/Radford Center: Monday - Friday, from 8:30am to 4:30pm.
Giles Center: Monday - Friday, from 8:00am to 4:00pm.

All appointments are done on a walk-in basis.

Discount Fee Program Application

***The Discount Fee Program is only available to Patients whose incomes fall at or below 200% of the Federal Poverty Line.**

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.

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	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 Discount Fee Program.

Signature of Patient or Legal Guardian: _____ Date: _____