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—6:00 pm Monday & 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.

Updated April 8, 2021

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

New Patient Paperwork Checklist

Please make sure the following items are completed/included prior to submitting your information. Appointments will not be scheduled until all necessary documents have been provided.

☐ Completed Registration Form with signature and date

☐ Copy of Photo ID

☐ Copy of Front and Back of insurance card(s)

☐ Signed Acknowledgments and Authorizations Form

☐ Signed HIPAA Form

☐ If patient is under 18, Signed Consent for Minor and/or Adult with Guardian Form

☐ Completed Sliding Fee Discount Program Application
Please note if you are seeking Dental services and are only enrolled in Medicaid, we highly recommend applying for the Discount Program since not all services are covered

☐ Proof of ALL Household Income

☐ Completed Health History Form

☐ Completed Dental Health History Form

There are **5** ways to return completed Patient Paperwork:

1. Drop off using the mailbox/drop box outside the Patient Services Office
2. Mail: Mail your completed application and accompanying documentation to the address below.
   Community Health Center of the NRV
   215 Roanoke Street
   Christiansburg, VA 24073
3. Fax: using a program like faxZERO or regular fax to (540) 382-1019
4. Online: Complete paperwork on our website at www.chcnrv.org
5. Email: Scan or take pictures of the completed paperwork and send to applications@chcnrv.org

The Community Health Center of the New River Valley wants to ensure that patients are able to access affordable quality healthcare and realize that it is not always possible to physically deliver eligibility documents to Center sites. To promote access to care, the Center provides opportunities for patients to submit documentation via electronic transmission, including, but not limited to: faxZero, Center website, and email. Patients should understand that these electronic platforms may not be secured or HIPAA compliant. As a result, their information could be susceptible to third party breaches. If patients have questions regarding the potential risk of electronic communication, they may ask to speak with the Corporate Compliance Manager, Ashley Slagel-Perry at 540-381-0820.

No Show Policy

Patients are responsible for keeping scheduled appointments and for contacting the office to cancel or reschedule their appointment. Last minute cancellations and no-shows limit access to other patients needing care. We require notification of cancellations or reschedules at least 24 hours prior to the appointment. Failing to keep your first appointment as a new patient with our center will result in you being placed in a "Sit and Wait" status. “Sit and Wait” status means you will not be given another scheduled appointment but will be required to call the office for a same-day appointment.

To avoid this, please make sure to call the office at least 24 hours prior to your appointment if you need to cancel or reschedule.

Updated April 8, 2021

Community Health Center of the New River Valley

Patient Registration Form

Preferred Location: ☐Christiansburg ☐ Giles (Pearisburg) ☐ Radford/Pulaski (Dublin)

Primary reason for contacting us: ☐Medical ☐ Dental ☐ Behavioral Health

How did you hear about us: _____

Name: _____ **Nickname/ Preferred Name**: _____
First **MI** **Last**

If under 18, Parent or Legal Guardian Name: _____

Mailing Address: _____ **City/State/Zip:** _____

Street Address: _____ **City/State/Zip:** _____

Primary Phone: _____ ☐ Home ☐ Cell ☐ Work

Secondary Phone: _____ ☐ Home ☐ Cell ☐ Work

Preferred Method of Contact: ☐Home Phone ☐ Cell Phone ☐ Email **Are you a student?** ☐Yes ☐No

Date of Birth: _____ **Social Security #:** _____ **Sex:** _____

Sexual Orientation (check one):
☐ Straight (not lesbian or gay)
☐ Lesbian/Gay ☐Bisexual
☐ Something Else
☐ Don't Know ☐Choose not to disclose

Gender Identity (check one):
☐ Male ☐Female
☐ Transgender Male/Female-to-Male
☐ Transgender Female/Male-to-Female
☐ Other ☐Choose not to disclose

Employment Status (check one):
☐ Full-Time ☐Part-Time
☐ Self-Employed ☐Retired
☐ Active Military ☐Reserved for National Assignment
☐ Not Employed ☐Other

Marital Status (check one):
☐ Divorced ☐Married
☐ Single ☐Partner
☐ Legally Separated
☐ Widowed

Emergency Contact:

_____ _____ _____
Name Relationship Phone

Email address: _____

Are you a (check 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 ☐Other

Ethnicity (check one): ☐Hispanic ☐Non-Hispanic

Primary Insurance Company Information

Primary Insurance Company Name: _____ Group Number: _____
Subscriber/policy/Medicaid Number: _____ Policy Holder Name: _____
Policy Holder DOB: _____ Relationship to the patient: _____
Policy Holder Address: _____

Payee Information	No Insurance Coverage
Is there a payee for your visit? ☐Yes ☐No If yes, Payee's Name: _____ Payee's Phone Number: _____ Payee's Address: _____ Please provide a copy of the approval to pay for services from your payee. Proof from your payee is required prior to your appointment being made.	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

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.

_____ **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).

_____**TELEVISIT APPOINTMENT CONSENT:** I understand that a TeleVisit appointment involves the use of electronic devices such as a computer, tablet, smart phone or telephone to enable two-way communication between the patient and their provider at different locations for the purpose of diagnosis, treatment, therapy, follow-up and /or education. I consent for my medical, dental, and/or behavioral health provider at the Community Health Center of the New River Valley to conduct a health care appointment with me through a TeleVisit appointment. I understand that the laws that protect privacy and the confidentiality of my medical information also apply to TeleVisits. I understand that my insurance carrier will have access to my medical records for quality review/audit as they would with an in-person office visit. I understand that I will be responsible for any copayments, deductibles or coinsurances that apply to my TeleVisit appointment. I understand that I have the right to withhold or withdraw my consent for the use of TeleVisits during my care at any time, without affecting my right to future in-person care or treatment.

_____**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.

Patient Name: _____ SS#: _____ Birthdate: _____

_____**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).

_____ _____

Signature of Patient or Parent/Legal Guardian Date

_____ _____

Relationship to Patient Witness Signature

Community Health Center of the New River Valley

Patient Name: _____ SS#: _____ Birthdate: _____

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____.

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

_____
Driver's License Number of Proxy Decision Maker

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
- Social Security Letter
- SNAP/WIC Benefits Letter
- Self -Employment Documentation (Taxes are Recommended)
- Letter from Employer on Company Letterhead
- Retirement/Pension
- Documentation of income from any other source
- If you have no income, we ask for a Letter of Support signed by the person who provides you with basic necessities

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.

Community Health Center of the New River Valley

Patient Name: _____ **DOB:** _____

Discount Fee Program Application

Would you like to apply for our Sliding Fee Discount Program? ☐Yes ☐No

If no, I understand that without having insurance and not applying for the Sliding Fee Discount Program, I will be responsible for my visits. I will be required to pay for my visits upfront, in full. If I have insurance, I will be responsible for any balance due after my insurance has been processed. Initial here: _____

***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, including yourself? _____ Please list them below.

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, and ALL others not listed.
Application will be rejected if documentation is not provided.

Employer and Income Information

Employer Name: _____ Employer Phone: _____
Date Employment Began: _____ Circle One: Full-Time Part-Time
How often are you paid? ☐Weekly ☐ Bi-weekly ☐Monthly ☐Bi-monthly ☐Other: _____
Amount you are paid before taxes: _____
Did your household file income taxes last year? ☐Yes ☐No Filing Status (circle one): Joint or Single

Unemployment and Disability Information

If Unemployed, date employment ended: _____
Does anyone receive unemployment wages? ☐Yes ☐No If yes, how much? _____
If Unemployed, has anyone applied for Disability? ☐Yes ☐No
Are you or anyone in your family planning on applying for disability? ☐Yes ☐No

Government Assistance and Insurance Information

Do you or anyone in your household have Medicaid? ☐Yes ☐No If yes, who? _____
Do you/spouse or any children under 18 receive Social Security Benefits? ☐Yes ☐No
Do you or others in the family have insurance? ☐Yes ☐No If yes, Name of Insurance: _____

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. I understand that eligibility in the program expires 12 months from my signature date below and that I must reapply after the eligibility period expires. I understand that I must inform the Center of any changes in my household (income and size) during this 12-month period.

Signature of Patient or Legal Guardian: _____ Date: _____

Community Health Center of the New River Valley

Health History Form

Patient Name: _____ Birthdate: _____ Date: _____
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

Patient Name: _____ Birthdate: _____ Date: _____

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: _____

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.