COMMUNITY HEALTH CENTER of the New River Valley

PATIENT REGISTRATION

Preferred Location: ◯ Christiansburg ◯ Pearisburg ◯ Dublin ◯ School Based Health Center

Primary reason for contacting us: ◯ Medical ◯ Dental ◯ Behavioral Health ◯ Substance Use Treatment

Name: _____ **Preferred Name:** _____

First MI Last

If under 18, Parent(s) or Legal Guardian(s) Name: _____

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

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

Primary Phone: _____ ◯ Home ◯ Cell ◯ Work

Secondary Phone: _____ ◯ Home ◯ Cell ◯ Work

Email Address: _____

Preferred Method of Contact: ◯ Home Phone ◯ Cell Phone ◯ Text ◯ Email

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

As a Community Health Center, we are required to request certain demographic information to ensure that our available services meet the needs of our community. The demographic information will be protected as a part of your Protected Health Information.

Marital Status: ◯ Single ◯ Divorced ◯ Married ◯ Widowed ◯ Partnered ◯ Legally Separated

Employment Status: ◯ Full-Time ◯ Part-Time ◯ Retired ◯ Self-Employed ◯ Not Employed ◯ Active Military ◯ Reserved for National Assignment ◯ Other

Are you a Migrant Agricultural worker? ◯ Yes ◯ No

Are you a Seasonal Agricultural worker? ◯ Yes ◯ No

Do you have permanent housing? ◯ Yes ◯ No ◯ Other

You are: ◯ U.S. Citizen ◯ U.S. Resident ◯ Other

Are you a United States Veteran? ◯ Yes ◯ No

What is your annual household income? _____

How many people live in your household? _____

Race: ◯ African American ◯ Native American ◯ Asian ◯ Pacific Islander ◯ White ◯ Other ◯ Choose not to disclose

Ethnicity: ◯ Hispanic ◯ Non-Hispanic ◯ Choose not to disclose

What is your primary language? _____

Do you require an interpreter? ◯ Yes ◯ No

Sexual Orientation:
◯ Straight (not lesbian or gay) ◯ Lesbian/Gay
◯ Bisexual ◯ Other
◯ Don't Know ◯ Choose not to disclose

What is your Gender Identity?
◯ Male ◯ Female
◯ Other / Additional gender category
◯ Transgender Female-to-male/male trans man
◯ Transgender Male-to-female/female trans woman
◯ Genderqueer, neither exclusively male nor female
◯ Choose not to disclose

What is your Gender Identity at birth? ◯ Male ◯ Female

Updated 4-2023

Patient Name: **DOB:**

Primary Insurance Company Information

Primary Insurance Company Name: **Group Number:**

Subscriber/Policy/Medicaid Number:

Policy Holder Name: **Policy Holder DOB/SSN:**

Relationship to the Patient:

Policy Holder Address:

◯ **No Insurance Coverage**

Secondary Insurance Company Information

Secondary Insurance Company Name: **Group Number:**

Subscriber/Policy/Medicaid Number:

Policy Holder Name: **Policy Holder DOB/SSN:**

Relationship to the Patient:

Policy Holder Address:

ACKNOWLEDGMENTS & AUTHORIZATIONS

CONSENT FOR TREATMENT: I authorize the employees, agents and staff of the 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.

TELEVISIT APPOINTMENT CONSENT: Televisit appointments involve 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 to conduct a health care appointment with me through a televisit appointment. I will be billed for this visit in the same way that I am billed for in office visits.

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 all patient medical and billing information to any physician or healthcare entity involved in my care. This authorization includes treatment, billing, quality assurance, collections, litigation, and to any entity that is directly or indirectly responsible for payment to or review of services provided by the Center.

BILLING INFORMATION: I will provide the Center with complete and accurate information so that billing data can be appropriately submitted. The Center will make every effort to submit claims to insurance companies and promptly provide statements.

FINANCIAL RESPONSIBILITY: I am financially responsible for all charges, whether or not paid by insurance. The Center does not participate in every insurance plan. Payment is expected at the time of service. I understand that I am responsible for any deductibles, co-payments, and any applicable percentage of remaining charges.

CERTIFICATION AND ACKNOWLEDGMENT: 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 Center's Notice of Privacy Practices (HIPAA).

Patient Name: **DOB:**

HIPAA

Release of Information: List any person whom can we can talk 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

CONSENT FOR MINOR/ADULT WITH GUARDIAN

List any adults who can consent to medical, dental, or behavioral health care for your minor child/adult with guardian in your absence:

Name	Phone Number	Relationship

CONSENT TO TREAT: I grant permission for the Center to perform medical, behavioral health, and/or dental care on my child with or without my presence. This may include routine diagnostic and medical treatment that the attending providers or others of the Center medical staff consider necessary. Services could include treatment for illness or injury, including over the counter medications or necessary prescriptions, well child exams, appropriate immunizations, behavioral health evaluations, dental cleanings, x-rays, fluoride treatments, sealants, and limited restorative dental treatments. Attempts will be made to notify the parent/guardian of the minor's appointment and to see if they wish to attend the visit. If no contact is made and all consents are in place, the Center will continue the appointment as needed and attempt contact the parent with follow-up information following the appointment including sending home a copy of the care summary.

SCHOOL BASED HEALTH CENTER

AUTHORIZATION FOR EXCHANGE OF HEALTH INFORMATION: I hereby authorize Community Health Center of the New River Valley's School Program to exchange health records with the appropriate school district for the purpose of providing care and treatment.

INFORMED CONSENT FOR GENERAL OR REMOTE SUPERVISION: I understand that the records for services provided by the dental hygienist will be reviewed by a Virginia licensed dentist providing the hygienist general supervision. I understand that treatment I receive from the dental hygienist is limited in scope and that it does not take the place of a regular dental examination or treatment by a licensed dentist. I understand that the dental hygienist may refer to a dentist or other specialist for further treatment when a dental condition requires more treatment that the dental hygienist can provide.

By signing below, I agree that I have provided accurate answers. I have reviewed the acknowledgments and authorizations and agree to adhere to the requirements as written. I have reviewed the Notice of Privacy Practices. My signature demonstrates consent and acknowledgment of all patient responsibilities and rights as outlined in this patient registration packet. It is my responsibility as a patient to contact the previous provider's office to transfer medical records. I can ask for a copy of my medical records at any time.

Signature of Patient or Legal Guardian: **Date:**

Patient Name: **DOB:**

DISCOUNT FEE PROGRAM APPLICATION

The Center offers a Discount Fee Program that reduces the cost of medical, dental, behavioral health, and substance use treatment.

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

Please list family members below:

Family Member (include yourself)	**Monthly Gross Income**

Document and provide proof of all income received. Two Paycheck stubs, Retirement, Social Security, Award Letters, Disability, Worker's Compensation, Unemployment, etc.

The information provided is, to the best of my knowledge and belief, accurate, and true. I authorize the release of all information which the 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:**

There are 4 ways to return completed Patient Paperwork:

1. **Mail** your completed application and accompanying documentation to the address below.
   Community Health Center of the NRV, 215 Roanoke Street, Christiansburg, VA 24073
2. **Fax** to (540)382-1019
3. **Online:** Complete paperwork on our website at **www.chcnrv.org**
4. **Email:** Scan or take pictures of the completed paperwork and send to **applications@chcnrv.org**