PATIENT REGISTRATION

Welcome to the Community Health Center of the New River Valley. Please submit completed applications via e-mail to Applications@chcnrv.org. Thank you for trusting us with your health care!

Preferred Location ○ Christiansburg ○ Dublin ○ Pearisburg ○ School-Based Health Center

Services ○ Medical ○ Dental ○ Behavioral Health ○ Substance Use Treatment

Patient Name (First Middle Last) **Preferred Name**

If patient is under 18 or is an adult with a guardian:

Parent/Guardian name	Phone Number	Relationship

Patient Date of Birth: **Patient SSN:**

Mailing Address: **City, State, Zip:**

Physical Address: **City, State, Zip:**

Home Phone: **Cell Phone:**

Email Address:

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

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.
If you are a parent/guardian: please complete this section based on patient information rather than yourself

Marital Status ○ Single ○ Divorced ○ Married ○ Widowed ○ Partnered ○ Separated

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

Are you a migrant agricultural worker? ○ Yes ○ No **Are you a seasonal agricultural worker?** ○ Yes ○ No

Are you currently homeless? ○ Yes ○ No **Do you have public housing?** ○ Yes ○ No

Are you a ○ US Citizen ○ Other **Are you a United States Veteran?** ○ Yes ○ No

Race ○ African American ○ American Indian/ Alaska Native ○ White ○ Pacific Islander ○ Native Hawaiian ○ Guamanian or Chamorro ○ Samoan ○ Asian ○ Asian Indian ○ Chinese ○ Filipino ○ Japanese ○ Korean ○ Vietnamese ○ Choose not to disclose

Ethnicity ○ Hispanic
- ○ Mexican, Mexican American, Chicano/a
- ○ Puerto Rican
- ○ Cuban
- ○ Another Hispanic, Latino/a, or Spanish origin

○ Non-Hispanic
○ Choose not to disclose

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

Gender at birth ○ Male ○ Female

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

What is your Primary Language?

Do you require an interpreter? ○ Yes ○ No

Annual Household Income

Number of household members

Patient Name:	Patient Date of Birth:

○ **Patient does not have insurance**	
○ **Primary (Medical) Insurance Information**	
Insurance Company:	Policy/Subscriber/Medicaid ID:
Group Number:	Insurance Phone Number:
Policy Holder Information	
Policy Holder Name:	Relationship to patient:
Policy Holder Date of Birth/SSN:	
Policy Holder Address:	

○ **Secondary Insurance Information (including dental insurance)**	
Insurance Company:	Policy/Subscriber/Medicaid ID:
Group Number:	Insurance Phone Number:
Policy Holder Information	
Policy Holder Name:	Relationship to Patient:
Policy Holder Date of Birth/SSN:	
Policy Holder Address:	

HIPAA

Release of Information: List any person 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	Emergency Contact?

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 to contact the parent with follow-up information following the appointment including sending home a copy of the care summary.

Patient Name: Patient Date of Birth:

ACKNOWLEDGEMENTS & AUTHORIZATIONS

Pulaski County School Based Health Center (if applicable)

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 than the dental hygienist can provide.

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. I am aware that local anesthesia or "numbing" for dental procedures poses risks including but not limited to hematoma, temporary or permanent numbness or altered sensation, needle breakage requiring retrieval, and self-inflicted soft tissue trauma

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 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 practices of medicine and dentistry are 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 paid by insurance or not. 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 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).

CONSENT TO COMMUNICATION: I consent to be contacted by regular mail, text, by email or by telephone (including a cell phone number) regarding any matter related to my account.

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.

Patient/Guardian Signature **Date**

Patient Name: Patient Date of Birth:

DISCOUNT FEE PROGRAM APPLICATION

The Center offers a Discount Fee Program that reduces the cost of medical, dental, behavioral health, and substance use treatment. To apply, please complete the information below.

Step 1: List all members of your household, including yourself:

Name	Monthly income (before taxes)

Step 2: Provide income documentation. This can be two Paycheck stubs, Retirement, Social Security, Award Letters, Disability, Worker's Compensation, Unemployment, etc.

If you do not have a source of income or are currently homeless or displaced, please let us know as soon as possible. We can help further reduce costs.

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 this program is active for 12 months and I must inform the Center of any changes in my household (income and size) during this 12-month period.

Parent/Guardian Signature **Date**

Please make sure to submit all applicable documents including a photo ID, insurance cards, and income documentation if applying for the discounted fee schedule.

HOW TO RETURN COMPLETED PAPERWORK

1. Complete on our website at www.chcnrv.org
2. Drop off or fax to any of our locations:

Christiansburg 215 Roanoke St Fax: 540-260-3428 E-mail: Applications@chcnrv.org	**Dublin** 5826 Ruebush Rd Fax: 540-307-5541 E-mail: Applications@chcnrv.org
Pearisburg 219 S. Buchanan St Fax: 540-921-3503 E-mail: Applications@chcnrv.org	**School Based Health Center** Check with your school Fax: 540-518-0005 E-mail: Applications@chcnrv.org