Community Health Centers

PATIENT REGISTRATION FORM

Verified By:
DATE REC/ENTERED: ___/___/___
STAFF INITIALS: _____

APPOINTMENT TYPE/STAFF USE ONLY ☐ **MEDICAL** ☐ **DENTAL**

☐ Riverside ☐ Safe Harbor ☐ Pearl Street ☐ South End ☐ Champlain Islands ☐ Good Health ☐ Winooski ☐ Essex

PATIENT INFORMATION *PLEASE COMPLETE (Fill out) entire form in Black or Blue Pen Only*

LAST NAME | FIRST NAME | MIDDLE INITIAL | NICKNAME/CHOSEN NAME

STREET ADDRESS | CITY | STATE | ZIP

SOCIAL SECURITY # | DATE OF BIRTH | HOME PHONE | DAY PHONE | CELL PHONE

EMAIL ADDRESS

PREFERRED CONTACT METHOD
☐ PHONE ☐ EMAIL ☐ TEXT MESSAGE

MARITAL STATUS
☐ Single ☐ Separated
☐ Married ☐ Widowed
☐ Divorced ☐ Civil Union

RACE
☐ African-American ☐ Native American
☐ Asian-American ☐ Pacific Islander
☐ Caucasian/White ☐ Multi-racial

Primary Language if Not English: _____
Do You Need Interpreter Services? ☐ YES ☐ NO

Ethnicity/Ethnic Origin: ☐ Hispanic ☐ Non-Hispanic

Primary Care Physician

AGRICULTURAL WORKER
☐ Migrant ☐ Seasonal

Are You a U.S. Veteran?
☐ Yes ☐ No

FAMILY FINANCIAL INFORMATION
As a Health Center that receives Federal funding, we are required to collect this information. All answers are confidential.

Family/Household Size: _____

Household Income: $ _____
☐ Weekly ☐ Annually
☐ Biweekly
☐ Monthly

LEGAL SEX
☐ MALE
☐ FEMALE

CURRENT GENDER
☐ MALE
☐ FEMALE

PRONOUNS (Optional):
_____

GENDER IDENTITY
☐ MALE
☐ FEMALE
☐ TRANSGENDER MALE (Female-to-Male/FTM)
☐ TRANSGENDER FEMALE (Male-to-Female/MTF)
☐ GENDERQUEER
☐ OTHER
☐ CHOOSE NOT TO DISCLOSE

SEXUAL ORIENTATION
☐ STRAIGHT or HETEROSEXUAL
☐ LESBIAN, GAY or HOMOSEXUAL
☐ BISEXUAL
☐ SOMETHING ELSE
☐ DON'T KNOW
☐ CHOOSE NOT TO DISCLOSE

HOUSING STATUS Are You Homeless? ☐ YES ☐ NO
If homeless, are you: ☐ Doubling Up (living with others) ☐ Shelter ☐ Street ☐ Transitional ☐ Unknown

PREFERRED PHARMACY

PHARMACY NAME | PHARMACY LOCATION

EMERGENCY CONTACT

NAME | RELATIONSHIP | PHONE NUMBER

RESPONSIBLE PARTY INFORMATION (Any patient under 18 must have a responsible party)

☐ **Patient** (18 years or older) ☐ **Custodial Parent** ☐ **Guardian** (proof of legal status required for treatment)

LAST NAME | FIRST NAME | MI

STREET ADDRESS | CITY | STATE | ZIP

DATE OF BIRTH | HOME PHONE

DENTAL INSURANCE INFORMATION

☐ **I currently have DENTAL insurance (see below)**
☐ **I currently DO NOT have DENTAL insurance**
☐ **I would like to apply for the SLIDING-FEE SCALE**

Dental Insurance Name: _____

Policy/ID Number: _____

☐ **I currently have secondary DENTAL insurance (see below)**

Dental Insurance Name: _____

Policy/ID Number: _____

MEDICAL INSURANCE INFORMATION

☐ **I currently have MEDICAL insurance (see below)**
☐ **I currently DO NOT have MEDICAL insurance**
☐ **I would like to apply for the SLIDING-FEE SCALE**

Medical Insurance Name: _____

Policy/ID Number: _____

☐ **I currently have secondary MEDICAL insurance (see below)**

Medical Insurance Name: _____

Policy/ID Number: _____

Community Health Centers

• RIVERSIDE • SAFE HARBOR • PEARL STREET • SCHOOL-BASED DENTAL CENTER •
• CHAMPLAIN ISLANDS • SOUTH END • GOOD HEALTH • WINOOSKI • ESSEX •

Consent for Treatment and Consent to Release Health Information

I. Consent for Treatment

I hereby give my consent for treatment for myself, or the named patient (of whom I am the parent or legal guardian who has the right to consent to treatment for the named patient) to the Community Health Centers (CHC). Treatment may include health screening, diagnosis, medical treatment, dental care, social services, mental health or drug and alcohol screening, assessment, diagnosis and treatment, and psychiatry services.

II. Consent to release health information:

I consent to the use within CHC and the disclosure to persons or organizations outside of CHC of my (or of the named patient for whom I am the parent or legal guardian) medical, dental, drug and alcohol, mental health, psychiatry and other treatment and health records ("health information") by CHC for the following purposes:

A. Use of health information by or for CHC for treatment, payment, and health care operations:

- Providing treatment by CHC staff.
- Conducting health care operations, including financial or quality assurance audits and/ or training.
- Bill your insurance company directly
- Payment for services provided by CHC. CHC is authorized to obtain payment for health care services and can provide health records to insurance companies, workers compensation insurers or other agencies that pay for health services, or other updated insurance information on file with CHC.

B. Disclosure of health information to persons or organizations outside of CHC for treatment purposes:

- CHC is authorized to provide all health information to other health providers or agencies who participate in your care. This includes past medical records from outside organizations. (An Individual release of information must be submitted for all family, friends, or other persons that you wish to access your Medical Record information.)

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III. Assignment of Benefits

I authorize CHC to bill and receive payment directly from Medicaid /Medicare or any other insurance carrier for services provided to me.

I hereby assign to CHC all payments from Medicaid, Medicare, or any health insurance policy for health care, rendered to me by CHC.

I understand I am responsible for any unpaid balances incurred because of my care at CHC.

I understand that, to the best of my knowledge, the demographic information I have provided is true and correct**.**

A copy of the CHC payment expectations is available at your request.

IV. Termination and restrictions of this consent:

A. I understand that I have the right to cancel this consent at any time in writing, cancelling this consent will not affect any actions taken by CHC in reliance of this consent before it was cancelled. If not previously cancelled, this consent will end on the following date: _____. If none is indicated, this consent will end three years after the last date of services to me.

B. I understand that I may request restrictions on the use or disclosure of my health information for the purposes described in this consent and that CHC may or may not agree to the request. I also understand that except for those restrictions on use or disclosure of health information to which it agrees, CHC will not be able to provide services to you (or the named patient) without this signed consent.

C. I have read this Consent for Treatment & Consent to Release of Health Information, and I understand and knowingly consent to its content.

I confirm that language access services were provided to me before I signed this Consent for Treatment & Consent to Release of Health Information form. ☐

REQUIRED

Name of Patient:_____Date of Birth_____
Patient Signature:_____Date:_____
Parent/Guardian:_____
Parent/Guardian Signature:_____Date:_____

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ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I hereby acknowledge and accept the Notice of Privacy Practices at the Community Health Centers of Burlington.

I recognize I can view a copy of the Privacy Practice at www.chcb.org/forms/ or obtain a paper copy at any CHC location.

I understand that the Privacy Practice is in accordance with the Health Insurance Portability and Accountability Act of 1996 (also known as, "HIPAA".)

Patient Name_____ Date of birth_____

Signature_____ Date_____

or

Signature of Guarantor / Personal Health Representative _____