Community Health Centers

TAARIIKHDA DUWAANKA/GELINTA:
XARFAHA URUURISKA MAGACA SHAQAALAHA:

FOOMKA DUWAAN GELINTA BUKAANKA

GOOBTA: ☐RIVERSIDE ☐SAFE HARBOR ☐PEARL STREET ☐SOUTH END ☐CHAMPLAIN ISLANDS ☐GOOD HEALTH ☐WINOOSKI ☐ESSEX

Xarun ahaan Caafimaad oo U Qalanka oo Federal, CHC waxay dawladu uga baahan tahay inay uruuriso oo macluumaadka soo socda. **Fadlan oggow in dhamaan jawaabuhu yihiin sir.**

MACLUUMAADKA BUKAANKA (FADLAN KUWAXA BUUXI FOOMKA OO DHAN QALIN MADAW AMA BULUUG AH OO KALIYA)

MAGACA DANBE	MAGACA KOWAAD	MAGACA AABAHA	MAGACA RUUXU DOORTO (HADII UU JIRO)

CINWAANKA JIDKA	MAGAALADA	GOBOLKA	BOOSTA

CINWAANKA BOOSTA (HADII UU KA DUWAN YAHAY KA RUUXU DEGAN YAHAY)

LAMBARKA SOOSHAAL SEKUURITIGA	TAARIIKHDA DHALASHADA	WAXA LOOGU YEEDHO RUUXA

TALEEFANKA GACANTA	TALEEFANKA SHAQADA	TALEEFANKA GURIGA

CINWAANKA IIMEELKA

QAABKA XIDHIIDHKA LA DOORBIDAYO
☐TALEEFAN ☐ FARIIN QORAAL AH
☐IIMEEL ☑ DAAQADA BUKAANKA

JINSIGA SHARCIGA AH
☐DHEDIG
☐LAB

JINSIGA WAKHTIGAN
☐DHEDIG
☐LAB

AQOONSIGA JINSIGA
☐DHEDIG
☐LAB
☐NAAG JINSIGA BEDESHAY (GABADH NIN LAGA DHEIGAY)
☐NIN JINSIGA BEDELEY (NIN NAAG ISKA DHIGAY)
☐KHANIIS
☐WAXKALE
☐MA DOONAYO IN AAN SHEEGO

RABITAANKA JINSIGA
☐JINSI CAADI AH
☐KHANIISAD, KHANIIS, ama KHANIIS
☐LABEEB
☐WAX KALE
☐MAGARANAYO
☐MA DOONAYO IN AAN SHEEGO

LUUQADA KOWAAD

MIYAAD U BAAHAN TAHAY ADEEGA TURJUBAADA?
☐HAA ☐MAYA

XAALADA GUURKA
☐KALI ☐KALA MAQAN
☐GUURSADAY ☐CARMAL
☐KALA TAGAY ☐ ISKA WADA NOOL

MA WAXA AAD TAHAY CIIDAN MARAYKAN OO HAWL GABAY?
☐HAA
☐MAYA

MA WAXA AAD TAHAY SHAQAALE BEEREED?
☐MAYA
☐SOO GELEYTI
☐XILIYEED

XAALADA GURYAYNTA
MA BILAA GURI AYAAD TAHAY? ☐HAA ☐MAYA
HADII AAD BILAA GURI TAHAY, MIYAAD: ☐LA TAHAY DULSAAR (LA NOOSHAHAY RUUX KALE) ☐HOY ☐JIDKA ☐KALA GUUR ☐LAMA GARANAYO

QOOMIYADA (DOORO DHAMAAN INTA AY KHUSAYSO)

AASIYAAN	DHALAD MARAYKAN AMA JASIIRADA BAASIFIGA	MADAW AMA MARAYKAN MADAW	HINDIDA MARAYKANKA AMA DHALAD ALASKA	CADAAN	MA DOONAYO IN AAN SHEEGO
☐JAYNIIS	☐DHALAD HAWAII	☐MADAW AMA MARAYKAN MADAW	☐HINDIDA MARAYKANKA AMA DHALAD ALASKA	☐CADAAN	☐MA DOONAYO IN AAN SHEEGO
☐VIETNAMESE	☐JASIIRADAHA KALE EE BAASIFIGA				
☐HINDIDA AASIYA	☐GUAMANIAN AMA CHAMORRO				
☐KOREAN	☐SAMOAN				
☐FILIPINO					
☐ JAPANESE					
☐ AASIYAAN KALE					

QOOMIYAD

HISBAANIG, LAATIINO, AMA ISKAANISH KASOO JEEDA	AAN AHAYN ISBAANIG, LATALINO/A, KASOO JEEDA ISBAANIK	MA DOONAYO IN AAN SHEEGO
☐MEKSIKAAN ☐MEKSIKAANKA MARAYKANKA ☐CHICANO	☐AAN AHAYN HISBAANIG, LAATIINO, AMA ISKAANISH KASOO JEEDA	☐MA DOONAYO IN AAN SHEEGO
☐PUERTO RICAN		
☐KUUBAAN		
☐HISBAANIG, LAATIINO, AMA ISKAANISH KASOO JEEDA		
☐HISBAANIG, LAATIINO, IYO ISKAANISH KASOO JEEDA KALE		

MAGACA BUKAANKA: **TAARIIKHDA DHALASHADA:**

MACLUUMAADKA DHAQAALE FADLAN GOOBAAB CABIRKA QOYSKA SAXDA AH IYO HEERKA DAKHLIGA QOYSKU INTA UU U DHAXEEYO SHAXDA HOOSE. *DHAMAAN JAWAABUHU WAA SIR*

TILMAAMAHA SABOOLNIMADA FEDERALKA 2024				
CABIRKA QOYSKA	**0-100% HEERKA SABOOLNIMADA FEDERALKA**	**101-150% HEERKA SABOOLNIMADA FEDERALKA**	**151-200% HEERKA SABOOLNIMADA FEDERALKA**	**WAX KA SAREEYA 200% HEERKA SABOOLNIMADA FEDERALKA**
	DAKHLIGA QOYSKA SANADKII WAXA UU U DHAXEEYAA IYADA OO LAGA DUULAYO CABIRKA QOYSKA			
1	$0 ILAA $15,060	$15,061 ILAA $22,590	$22,591 ILAA $30,120	$30,121 & WIXII KA SAREEYA
2	$0 ILAA $20,440	$20,441 ILAA $30.6060	$30,661 ILAA $40,880	$40,881 & WIXII KA SAREEYA
3	$0 ILAA $25,820	$25,821 ILAA $38,730	$38,731 ILAA $51,640	$51,641 & WIXII KA SAREEYA
4	$0 ILAA $31,200	$31,201 ILAA $46,800	$46,801 ILAA $62,400	$62,401 & WIXII KA SAREEYA
5	$0 ILAA $36,580	$36,581 ILAA $54,870	$54,871 ILAA $73,160	$73,161 & WIXII KA SAREEYA
6	$0 ILAA $41,960	$41,961 ILAA $62,940	$62,941 ILAA $83,920	$83,921 & WIXII KA SAREEYA
7	$0 ILAA $47,340	$47,341 ILAA $71,010	$71,011 ILAA $94,680	$94,681 & WIXII KA SAREEYA
8	$0 ILAA $52,720	$52,721 ILAA $79,080	$79,081 ILAA $105,440	$105,441 & WIXII KA SAREEYA
9	$0 ILAA $58,100	$58,101 ILAA $87,150	$87,151 ILAA $116,200	$116,201 & WIXII KA SAREEYA
10	$0 ILAA $63,480	$63,481 ILAA $95,220	$95,221 ILAA $126,960	$126,961 & WIXII KA SAREEYA
*****	**KU DAR $5,380 RUUXII KASTA OO DHEERAAD AH EE XUBIN QOYSKA AH.*	**KU DAR $8,070 RUUXII KASTA OO DHEERAAD AH EE XUBIN QOYSKA AH.*	**KU DAR $10,760 RUUXII KASTA OO DHEERAAD AH EE XUBIN QOYSKA AH.*	

MACLUUMAADKA CAYMISKA ILKAHA

☐ Waxa aan leeyahay caymiska ilkaha wakhtigan.

☐ Ma haysto wakhti xaadirkan caymiska ilkaha.

☐ Ma doonaysaa inaad dalbato miisaanka heerka.

MAGACA SHIRKADA CAYMISKA ILKAHA:
LAMBARKA/AQOONSIGA CAYMISKA
MAGACA RUUXA KU QORAN CAYMISKA:

MACLUUMAADKA CAYMISKA ILKAHA EE LABAAD:
MAGACA SHIRKADA CAYMISKA ILKAHA:
LAMBARKA/AQOONSIGA CAYMISKA
MAGACA RUUXA KU QORAN CAYMISKA:

MACLUUMAADKA CAYMISKA CAAFIMAADKA

☐ Waxa aan leeyahay caymiska caafimaad wakhtigan.

☐ Ma haysto wakhti xaadirkan caymiska caafimaad.

☐ Ma doonaysaa inaad dalbato miisaanka heerka.

MAGACA SHIRKADA CAYMISKA CAAFIMAADKA:
LAMBARKA/AQOONSIGA CAYMISKA
MAGACA RUUXA KU QORAN CAYMISKA:

MACLUUMAADKA CAYMISKA CAAFIMAADKA EE LABAAD:
MAGACA SHIRKADA CAYMISKA CAAFIMAADKA:
LAMBARKA/AQOONSIGA CAYMISKA
MAGACA RUUXA KU QORAN CAYMISKA:

FARMASIGA AAD DOOR BIDO

MAGACA FARMASIGA **GOOBTA FARMASIGA**

MACLUUMAADKA XIDHIIDHKA XAALADA DEGDEGA AH

MAGACA **XIDHIIDHKA** **TALEEFAN LAMBARKA**

MACLUUMAADKA CIDA MASUULKA AH (WIXII BUKAAN AH EE KA YAR 18 JIR WAA INUU LEEYAHAY CID KA MASUUL AH)

☐ **WAALIDKA GACANTA KU HAYA**

☐ **KORIYAHA** (CADAYNTA XAALADA SHARCIGA AH EE U BAAHAN DAAWAYNTA CHC)

MAGACA DANBE **MAGACA KOWAAD** **MAGACA AABAHA** **MAGACA RUUXU DOORTO (HADII UU JIRO)**

CINWAANKA JIDKA **MAGAALADA** **GOBOLKA** **BOOSTA**

TAARIIKHDA DHALASHADA **LAMBARKA TALEEFANKA**

Community Health Centers

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

Ogolaanshaha Daawaynta iyo Ogolaanshaha Bixinta Macluumaadka Caafimaad

I. Ogolaanshaha Daawaynta

Waxa aan halkan ku ogolaaday daawaynta naftayda, ama bukaanka magiciisa la sheegey (oo aan anigu u ahay waalidkii ama koriyihiisa sharciga ah oo xaq u leh inuu u ogolaado daawaynta bukaanka magiciisa lagu sheegey kor) Xarumaha Caafimadka Bulshada (CHC). Daawaynta waxaa kamid ah shaybaadhka, baadhitaanka iyo daawaynta caafimaad, daryeelka ilkaha; adeegyada bulshada; caafimaadka iyo/ama shaybaadhka caafimaadka maskaxda ama khamrida, qiimaynta, xanuunka iyo daawaynta, adeegyada iyo adeegyada dhakhtarka cilmi nafsiga.

II. Ogolaanshaha bixinta macluumaadka caafimaadka:

Waxa aan ogolaaday isticmaalka CHC iyo in la siiyo dad iyo hay'ado ka baxsan CHC duwaanadayda (ama kuwa bukaanka la sheegey magiciisa ee aan waalidka ama koriyaha u ahay) caafimaad, daryeelka ilkaga, khamrida iyo mukhaadaraadka, caafimaadka maskaxda, dhakhtarka cilmi nafsiga iyo daawaynaha kale iyo caafimaadka ("macluumaadka cafimaadka") ee CHC wixii ah ujeedada soo socota:

A. Isticmaalka macluumaadka caafimaadka ee ama loogu talo geley daawaynta, bixinta iyo shaqada daryeelka caafimaad ee CHC:

- Bixinta daawaynta shaqaalaha CHC:
- Qabashada shaqooyinka daryeelka caafimaad, oo waxaa ku jiwa, hantidhawrka dhaqaale ama tayada caymiska iyo/ama tobobarka.
- Toos ugu dalicida shirkadaada caymiska ah lacagta
- Lacagta adeegyada ay bixisay CHC. CHC waxaa loo ogol yahay inay siiso adeegyada daryeelka caafimaadka iyo inay siiso duwaanada caafimaadka la bixiyay shirkadaha caymiska, caymiska gunada shaqaalaha ama hay'adaha kale ee bixiya adeegyada caafimaadka, iyo macluumaadka caymiska ee ugu danbeeya ee kale ee ku jira faylka CHC hayso.

B. Bixinta macluumaadka caafimaadka ee qoyska ama hay'adaha ka baxsan wixii ah ujeedo daawaynta CHC:

- CHC waxay sisaa dhaaman macluumaadka caafimaadka bixiyayaasha caafimaadka ee kale ama hay'adaha ku jira daryeelkaaga. Tan waxaa kamid ah duwaanada caafimaadka ee hore ee hay'adaha banaanka ah. (Macluumaadka si shakhsi ahaaneed ay tahay in loo bixiyo waa in loo gudbiyo dhamaan qoyska, asxaabta, ama shakhsiyadka kale ee doonaya inay galaan macluumaadkaaga Duwaanka Caafimaadka.)

III. Ku Qorida Gunooyinka

Waxa aan u ogolaaday CHC inay ku dalacdo oo ay si toos ah uga hesho lacagta Medicaid/Medicare ama wixii caymis ah ee adeegyada la i siiyay.

Waxa aan halkan ku saxeexayaa in CHC ay dhamaan lacagta Medicaid, Medicare, ama wixii kale ee caymiska caafimaadka ah ee daryeelka caafimaadka, ee ay i siisay CHC.

Waxa aan fahansanahay in aan ka masuul ahayn wixii baaqi lacag ah ee aan galo ee daryeelkayga CHC.

Waxa aan fahansanahay in, ilaa inta aan ogahay, macluumaadka deegaanka ee aan bixiyay ay yihiin run oo sax yihiin**.**

Nuqulka filashooyinka lacagta CHC waxaa la heli karaa marka la dalbado.

IV. Joojinta iyo xadidaada ogolaanshahan:

A. Wax aaan fahamsanahay in aan xaq u leeyahay in aan joojiyo ogolaanashahan wakhtiga kasta iyada oo qoraal ah, joojinta ogolaanshahan ma saamayn doono wixii talaabooyin ah ee ay qaaday CHC iyada oo ka duulaysa ogolaanshahan kahor inta aan la joojin. Hadii aan hore u joojiyay, ogolaanshahan waxa uu ku eeg yahay taariikhda soo socda: _____. Hadii aan midna la sheegin, ogolaanshahan waxa uu ku eeg yahay sadex sano kadib taariikhda ugu danbaysa ee adeegyada la i siiyo.

B. Waxa aan fahansanahay in aan dalban karo xadidaado isticmaalka ama bixinta macluumaadkayga caafimaad wixii ujeedo lagu sheegey ogolaanshahan iyo in CHC ay ogolaan karto ama ayna ogolaanaynin dalabka. Waxa aan fahansanahay in marka laga tago wixii xadidaado ah ee isticmaal ama bixin macluumaadka caafimaad ee lagu heshiiyay, CHC inayna siinin adeegyada adiga (ama bukaanka lagu sheegey magiciisa kor) iyada oo aan la heynin ogolaanshe saxeexan.

C. Waxa aan akhriyay Ogolaanshaha Daawaynta & Ogolaanshaha Bixinta Macluumaadka Caafimaad oo aan fahmay oo aniga oo og ayaan ogolaadan ogolaanshaheeda.

Waxaan xaqiijinayaa in la i siiyay adeegyada luuqada kahor inta aanan saxeexin foomka Ogolaanshahan Daawaynta & Ogolaanshaha Bixinta Macluumaadka Caafimaadka.

Waxaan halkan ku qirayaa in la i siiyay koobiga Ogeysiiska Habdhaqanka Qarsoonnimada waxaanan fahansanahay in CHC ay u isticmaali doonto macluumaadkayga caafimaad si waafaqsan sharciga sirta.

Magaca Bukaanka: _____ Taariikhda Dhalashada: _____
Saxeexa Bukaanka: _____ Taariikhda: _____
Waalidka/Koriyaha: _____
Saxeexa Waalidka/Koriyaha: _____ Taariikhda: _____

LOO BAAHAN YAHAY

Community Health Centers

DATE REC/ENTERED:
STAFF INITIALS:

PATIENT REGISTRATION FORM

LOCATION: ☐RIVERSIDE ☐SAFE HARBOR ☐PEARL STREET ☐SOUTH END ☐CHAMPLAIN ISLANDS ☐GOOD HEALTH ☐WINOOSKI ☐ESSEX

As a Federally Qualified Health Center, CHC is required by the federal government to collect the following information. **Please note that all responses are confidential.**

PATIENT DEMOGRAPHICS (PLEASE FILL OUT ENTIRE FORM IN BLACK OR BLUE PEN ONLY)

LAST NAME	FIRST NAME	MIDDLE INITIAL	CHOSEN NAME (IF ANY)

STREET ADDRESS	CITY	STATE	ZIP CODE

MAILING ADDRESS (IF DIFFERENT THAN PHYSICAL ADDRESS)

SOCIAL SECURITY NUMBER	DATE OF BIRTH	PRONOUNS

CELL PHONE	WORK PHONE	HOME PHONE

EMAIL ADDRESS

PREFERRED CONTACT METHOD
☐PHONE ☐ TEXT
☐EMAIL ☐ PATIENT PORTAL

LEGAL SEX
☐FEMALE
☐MALE

CURRENT GENDER
☐FEMALE
☐MALE

GENDER IDENTITY
☐FEMALE
☐MALE
☐TRANSGENDER MALE (FEMALE-TO-MALE)
☐TRANSGENDER FEMALE (MALE-TO-FEMALE)
☐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

PRIMARY LANGUAGE

DO YOU NEED INTERPRETER SERVICES?
☐YES ☐NO

MARITAL STATUS
☐SINGLE ☐SEPERATED
☐MARRIED ☐WIDOWED
☐DIVORCED ☐ CIVIL UNION

ARE YOU A U.S. VETERAN?
☐YES
☐NO

ARE YOU AN AGRICULTURAL WORKER?
☐NO
☐MIGRANT
☐SEASONAL

HOUSING STATUS
ARE YOU HOMELESS? ☐YES ☐NO
IF HOMELESS, ARE YOU: ☐DOUBLING UP (LIVING WITH OTHERS) ☐SHELTER ☐STREET ☐TRANSITIONAL ☐UNKNOWN

RACE (SELECT ALL THAT APPLY)

ASIAN	NATIVE HAWAIIAN OR PACIFIC ISLANDER	BLACK OR AFRICAN AMERICAN	AMERICAN INDIAN OR ALASKA NATIVE	WHITE	CHOOSE NOT TO DISCLOSE
☐CHINESE	☐NATIVE HAWAIIAN	☐BLACK OR AFRICAN AMERICAN	☐AMERICAN INDIAN OR ALASKA NATIVE	☐WHITE	☐CHOOSE NOT TO DISCLOSE
☐VIETNAMESE	☐OTHER PACIFIC ISLANDER				
☐ASIAN INDIAN	☐GUAMANIAN OR CHAMORRO				
☐KOREAN	☐SAMOAN				
☐FILIPINO					
☐ JAPANESE					
☐ OTHER ASIAN					

ETHNICITY

HISPANIC, LATINO/A, OR SPANISH ORIGIN	NOT HISPANIC, LATINO/A, OR SPANISH ORIGIN	CHOOSE NOT TO DISCLOSE
☐MEXICAN ☐MEXICAN AMERICAN ☐CHICANO	☐NOT HISPANIC, LATINO/A, OR SPANISH ORIGIN	☐CHOOSE NOT TO DISCLOSE
☐PUERTO RICAN		
☐CUBAN		
☐ HISPANIC, LATINO/A, OR SPANISH ORIGIN		
☐ANOTHER HISPANIC, LATINO/A, AND SPANISH ORIGIN		

Patient Name: Date of Birth:

FINANCIAL INFORMATION: PLEASE CIRCLE THE APPROPRIATE FAMILY SIZE AND CORRESPONDING HOUSEHOLD INCOME RANGE ON THE TABLE BELOW. *ALL RESPONSES ARE CONFIDENTIAL*.

2024 FEDERAL POVERTY GUIDELINES				
FAMILY SIZE	**0-100% FEDERAL POVERTY LEVEL**	**101-150% FEDERAL POVERTY LEVEL**	**151-200% FEDERAL POVERTY LEVEL**	**OVER 200% FEDERAL POVERTY LEVEL**
	HOUSEHOLD ANNUAL INCOME RANGE BASED ON FAMILY SIZE			
1	$0 TO $15,060	$15,061 TO $22,590	$22,591 TO $30,120	$30,121 & OVER
2	$0 TO $20,440	$20,441 TO $30,6060	$30,661 TO $40,880	$40,881 & OVER
3	$0 TO $25,820	$25,821 TO $38,730	$38,731 TO $51,640	$51,641 & OVER
4	$0 TO $31,200	$31,201 TO $46,800	$46,801 TO $62,400	$62,401 & OVER
5	$0 TO $36,580	$36,581 TO $54,870	$54,871 TO $73,160	$73,161 & OVER
6	$0 TO $41,960	$41,961 TO $62,940	$62,941 TO $83,920	$83,921 & OVER
7	$0 TO $47,340	$47,341 TO $71,010	$71,011 TO $94,680	$94,681 & OVER
8	$0 TO $52,720	$52,721 TO $79,080	$79,081 TO $105,440	$105,441 & OVER
9	$0 TO $58,100	$58,101 TO $87,150	$87,151 TO $116,200	$116,201 & OVER
10	$0 TO $63,480	$63,481 TO $95,220	$95,221 TO $126,960	$126,961 & OVER
*****	**ADD $5,380 PER EACH ADDITIONAL FAMILY MEMBER.*	**ADD $8,070 PER EACH ADDITIONAL FAMILY MEMBER.*	**ADD $10,760 PER EACH ADDITIONAL FAMILY MEMBER*	

DENTAL INSURANCE INFORMATION

☐ I currently have dental insurance.
☐ I currently DO NOT have dental insurance.
☐I would like to apply for the sliding-fee scale.

DENTAL INSURANCE NAME:
POLICY/ID NUMBER:
POLICY HOLDER NAME:

SECONDARY DENTAL INSURANCE INFORMATION:
DENTAL INSURANCE NAME:
POLICY/ID NUMBER:
POLICY HOLDER NAME:

MEDICAL INSURANCE INFORMATION

☐ I currently have medical insurance.
☐ I currently DO NOT have medical insurance.
☐I would like to apply for the sliding-fee scale.

MEDICAL INSURANCE NAME:
POLICY/ID NUMBER:
POLICY HOLDER NAME:

SECONDARY MEDICAL INSURANCE INFORMATION:
MEDICAL INSURANCE NAME:
POLICY/ID NUMBER:
POLICY HOLDER NAME:

PREFERRED PHARMACY

PHARMACY NAME **PHARMACY LOCATION**

EMERGENCY CONTACT INFORMATION

NAME **RELATIONSHIP** **PHONE NUMBER**

RESPONSIBLE PARTY INFORMATION (ANY PATIENT UNDER 18 YEARS OLD MUST HAVE A RESPONSIBLE PARTY)

☐**CUSTODIAL PARENT**
☐**GUARDIAN** (PROOF OF LEGAL STATUS REQUIRED FOR TREATMENT AT CHC)

LAST NAME **FIRST NAME** **MIDDLE INITIAL** **CHOSEN NAME (IF ANY)**

STREET ADDRESS **CITY** **STATE** **ZIP CODE**

DATE OF BIRTH **PHONE NUMBER**

Community Health Centers

• RIVERSIDE • SAFE HARBOR • PEARL STREET • SCHOOL-BASED DENTAL CENTER •
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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.)

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. ☐

I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices and understand CHC will use my protected health information in accordance with privacy law. ☐

REQUIRED

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