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 ☐SEPARATED
☐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 •
• 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.)

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:_____