Patient Information

Patient Name	Last	First	Middle Initial	Date of Birth

Home Address	House #	Street	Apt #	City	State	Zip

Mailing Address	House #	Street	Apt #	City	State	Zip

☐ Check this box and leave mailing address blank if it is the same as your home address

Email Address		
	May we contact you via email? (circle one)	Yes | No

Home Phone		
( ) -	May we leave a voicemail? (circle one)	Yes | No

Cell Phone		
( ) -	May we leave a voicemail? (circle one)	Yes | No
	May we send a text message? (circle one)	Yes | No

Work Phone		
( ) -	May we leave a voicemail? (circle one)	Yes | No

Gender: Female | Male	Social Security #: - -

Pharmacy Name:

Insurance Information (Please copy this information from your insurance card)

☐ Check this box if the patient does not have any health insurance.

Primary Insurance

Carrier (Company)	Group ID	Office Visit Copay
		$

Subscriber Name	Subscriber Date of Birth

Policy Holder ID (for the patient)	Subscriber's Relation to Patient (circle one)
	Self | Spouse | Partner | Child | Other _____

Secondary Insurance

Carrier (Company)	Group ID	Office Visit Copay
		$

Subscriber Name	Subscriber Date of Birth

Policy Holder ID (for the patient)	Subscriber's Relation to Patient (circle one)
	Self | Spouse | Partner | Child | Other _____

Patient Information (page 2)

Responsible Party

☐ I am the patient. (You may skip this section; go to additional Information)

If you are the parent/legal guardian or are otherwise responsible for authorizing care and paying bills for the patient named above, please provide your name and contact information below.

The patient is my (circle one): Spouse | Partner | Child | Other _____

Name	Last	First	Date of Birth	SSN

Mailing Address	House #	Street	Apt #	City	State	Zip

Email Address

Additional PATIENT Information

Please circle one option for each question below. We are required to ask these questions, but you may skip any you are not comfortable answering.

Marital Status? Single | Married | Partner | Widowed | Divorced | Legally Separated

Employment Status? Full-time | Part-time | Not Employed | Self-Employed | Retired | Active Military | Student

Race? American Indian/Alaska Native | Asian | Native Hawaiian/Other Pacific Islander | Black/African American | White/Caucasian

Ethnicity? Hispanic/Latino | Not Hispanic/Latino

Primary Language? English | Spanish | Other _____
Do you require interpretation services? Yes | No

Are you a veteran? Yes | No

Are you a public housing resident? Yes | No **If yes, which housing development?** _____

Are you homeless? Yes | No **If yes, what is your status?** Street | Doubling Up | Transitional Housing | Shelter _____

Is your main employment in agriculture on a seasonal basis (Seasonal Agricultural Worker)? Yes | No

Do you move (migrate) through the year for agricultural work (Migratory Agricultural Worker)? Yes | No

Sexual Orientation? Straight/Heterosexual | Lesbian or Gay | Bisexual | Other | Don't Know | Choose not to disclose

Gender Identity? Male | Female | Transgender/Female-to-Male | Transgender/Male-to-Female | Other | Choose not to disclose

Acknowledgements

1) I voluntarily consent to receiving services at Christ Community Health Services Augusta (CCHSA). I give permission to all CCHSA Providers to use diagnostic and treatment procedures they deem necessary for proper medical/dental management and treatment.
2) I assign the payment of claims on my behalf to CCHSA. I understand some of the services I receive may not be covered by my third-party payor (Medicare, Medicaid, other insurance), and I am responsible for paying these amounts.
3) I understand payment in full is expected before I receive services at CCHSA. This includes payment of all service fees, copays, and/or coinsurance amounts as discounted based on my fee discount eligibility.
4) I understand CCHSA will not write prescriptions for narcotics at a patient's first appointment. I further understand CCHSA Providers do not guarantee that they will continue a narcotic prescription.
5) I understand CCHSA may discharge me as a patient for cause, or if I do not see a Provider at CCHSA in a 3 year time period.

I affirm all information provided in this Patient Information form is true and accurate to the best of my knowledge.

_____ _____ _____

SIGNATURE of Patient or Patient's Parent/Guardian | PRINTED NAME of Patient or Patient's Parent/Guardian | DATE

Protection of Health Information – For Adults

Patient Name	Last	First	Middle Initial	Date of Birth

Christ Community Health Services Augusta (CCHSA) is allowed to share the Patient's Protected Health Information (PHI) with only the people you list below. This PHI includes but is not limited to the Patient's health history, list of medicines, and lab results. These people will also be allowed to pick up the Patient's prescriptions.

AUTHORIZED ACCESS TO PATIENT'S PHI

Full Name	Date of Birth	Phone Number(s)	Relationship to Patient	May we leave a message on this person's phone?
				Yes | No
				Yes | No
				Yes | No
				Yes | No

EMERGENCY CONTACT

Listing someone here gives permission to access the patient's PHI ONLY as necessary in the case of an emergency.

Full Name	Date of Birth	Phone Number(s)	Relationship to Patient	May we leave a message on this person's phone?
				Yes | No

CCHSA uses Health Information Exchanges (HIEs) to share PHI with other doctors' offices, hospitals, pharmacies, etc. HIEs make it easier and faster for all your healthcare providers to have access to your health information so they can give you the best care possible. Only Network Participants of HIEs who are relevant to a patient's care are allowed to share and view patients' PHI through HIEs.

You have the right to ask that we do not share your PHI through HIEs. Whether you participate will not affect your access to services at CCHSA. If you do not want your PHI to be shared through HIEs, please check this box.

☐ Opt Out

Acknowledgements

1) I have been given the chance to review the Notice of Privacy Practices.
2) I give permission for CCHSA to use and to share the Patient's PHI with necessary third-parties for payment, for treatment, and for general healthcare operations.
3) I give permission for CCHSA to share the Patient's PHI and to release the Patient's prescriptions to each of the people listed in the AUTHORIZED ACCESS TO PHI table above. I have the legal right to give this authority to the people listed on this form.
4) I understand that I have the right to restrict how CCHSA shares PHI and I can cancel this permission any time.

_____ _____ _____

SIGNATURE of Patient or Patient's Representative PRINTED NAME of Patient or Patient's Representative DATE

Application for Fee Discounts

CHRIST COMMUNITY HEALTH

This Application for Fee Discounts determines whether you qualify to receive healthcare services at discounted prices. Please read the "Fee Discounts Overview" flyer and the instructions on this application for information that will help you decide who is considered a part of your Household/Family and what is considered as income.

For Office Use Only:

Household/Family Size: _____
Household/Family Annual Income: $_____

Date: _____ Initials: _____

You will need to fill out this application and provide updated proof of income documents each year, or whenever your Household/Family size or income changes. Please ask any of our Patient Services staff members to help you fill out this application or answer any questions, if needed.

☐ *Please check this box and sign below if you do not wish to apply for fee discounts.*

Household/Family Size

Please list all members of your Household/Family who live together most of the time and depend on each other's incomes.

Head of Household / Responsible Party (must be the one completing this application)

	Last Name	First Name	Date of Birth
1			

Other Household/Family Members

	Last Name	First Name	Date of Birth	How is this person related to you?
2				☐ Spouse ☐ Child ☐ Partner ☐ Grandchild ☐ Other _____
3				☐ Spouse ☐ Child ☐ Partner ☐ Grandchild ☐ Other _____
4				☐ Spouse ☐ Child ☐ Partner ☐ Grandchild ☐ Other _____
5				☐ Spouse ☐ Child ☐ Partner ☐ Grandchild ☐ Other _____
6				☐ Spouse ☐ Child ☐ Partner ☐ Grandchild ☐ Other _____
7				☐ Spouse ☐ Child ☐ Partner ☐ Grandchild ☐ Other _____
8				☐ Spouse ☐ Child ☐ Partner ☐ Grandchild ☐ Other _____

Application for Fee Discounts (page 2)

Household/Family Income

Please enter all forms of income (before taxes) earned by each member of your Household/Family, per month.

Household/ Family Member Name	Wages/Paycheck	Self-Employment & Odd Jobs Income	Pension/Retirement & Social Security & Disability Income	Food Stamps & Housing Vouchers & Other Public Assistance	Alimony & Child Support	Unemployment Income	Support from Family/ Friends & Other Forms of Income	Total
							$	

Acknowledgements

Please initial below acknowledging that you understand each of the following:

_____ I have read and understand the "Fee Discounts Overview" and agree to follow its guidelines.

_____ I understand that I must provide the necessary proof of income documents to qualify for fee discounts.

_____ I will notify Christ Community Health Services as soon as possible if the size or income of my Household/Family changes.

_____ Based on the information shared in this application and the assessment made by CCHSA staff, I agree to pay the discounted fee required of me for each visit. I understand that the fee I have to pay may be different depending on the type of services I am receiving.

_____ I understand I may be required to pay additional fees for certain laboratory testing, supplies/equipment, or for dental services not considered "basic", and that these amounts will be discussed with me prior to receiving services.

I affirm all information provided in this Application for Fee Discounts is true and accurate to the best of my knowledge. I give appropriate CCHSA staff permission to investigate any information provided in this application. I understand providing false information will result in no longer being eligible for fee discounts.

_____ _____

Applicant's Signature Date

No-Show Policy Acknowledgement

Your healthcare providers want to make sure that you and other area residents have access to high quality medical and dental care when you need it. To ensure maximum access to care for all of our patients, please be aware of and follow the following Appointment/No-Show Policy.

Keeping Scheduled Appointments & Arriving Early

We will do our best to remind you of your upcoming medical or dental appointment by phone, mail, or email. But it is *your responsibility to remember your appointment date and time*.

You should arrive 15-30 minutes *before* your scheduled appointment time. If you cannot make it or think you will be late to your scheduled appointment, please let us know *as soon as possible*. If you are having a hard time finding transportation, please let us know. We might be able to connect you to resources that can help.

What is considered a "No-Show"?

- If you arrive more than 15 minutes after your scheduled appointment time, or
- If you do not call to cancel or reschedule your appointment *before 3pm the day before your appointment*.

What happens when I "No-Show" my appointment?

When you don't come to your appointment, you take an appointment time away from someone else who could have used it. **Because there are so many people in our community who do not have access to quality medical and dental services, *"No-Shows" are taken very seriously*.**

New Patients:
If you No-Show your first medical appointment, you may be given one more chance to schedule an appointment. If you No-Show that appointment, you will not be allowed to schedule another appointment for one year.

If you No-Show your first dental appointment, you will not be allowed to schedule future appointments. You may be placed on the "Same Day" appointment list at the discretion of appropriate dental staff.

Established Patients:
If you No-Show 2 or more appointments in a 12-month period, you may lose your privilege to schedule appointments in the future. Depending on the situation, your medical or dental provider may allow you to still make appointments. These appointments might be "Same Day" appointments. If you show that you can keep appointments regularly, you may be allowed to make regular appointments again.

Patients under age 18 may be granted an exception to the No-Show Policy at the discretion of a medical or dental provider.

I understand and agree to abide by this No-Show Policy.

_____ _____

Patient or Patient's Parent/Guardian Signature Date