To proclaim Jesus Christ as Lord and to demonstrate His love by providing affordable, quality primary health care.

Welcome to Christ Community Health Services!

Thank you for choosing us to be your healthcare partner and entrusting us with your care. Our goal is to provide the highest quality, most compassionate care to our patients and their loved ones.

To make sure your first visit goes smooth, with the most time spent on you, please fill out the enclosed forms before you come to your visit and bring them with you.

Please arrive 30 minutes early to register at our reception area. You must bring a valid photo ID. Accepted forms of photo IDs include a state-issued driver's license, state issued identification card or a passport. Proper patient identification protects your security and privacy.

If you have insurance, please bring your insurance card with you. We will need a copy of it to make sure we can bill your insurance company.

We have also enclosed an application for our discount program. You can apply for help and reduce the amount you must pay for your care. Please complete it also before coming and please be sure to bring the documents that show how much money you make so we can determine if you can be approved for our sliding fee schedule. You can apply for this whether you have no insurance or if you need some help with your insurance out of pocket amounts.

Please also bring all your prescription and over-the-counter medications with you at each visit.

If for any reason you find that you are unable to keep your scheduled appointment, please call our office at least 24 hours in advance of the visit.

Once again, we would like to thank you for choosing us as your primary health care provider. We look forward to working with you.

Sincerely,

The Christ Community Health Team

P.O. Box 2344, Augusta, GA 30903
Phone (706) 922-0600 Medical Records Fax (706) 922-0603
www.cchsaugusta.org

Patient Information

CHRIST COMMUNITY HEALTH

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) May we send a text message? (circle one)	Yes | No 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 Staff to use diagnostic and treatment procedures they deem necessary for proper medical, dental, behavioral and spiritual care.
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 period.
6) I understand Christ Community is an integrated care system, meaning that all providers work together to coordinate my care. I understand all my visit notes are part of my medical record. This means that other providers at Christ Community who care for me may have access to this information.
7) Some services at Christ Community Health may include the use of telemedicine equipment and interaction with providers who are not physically onsite. These services are conducted via secure lines and are not videotaped, routed through the internet, or saved in any means.

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

CHRIST COMMUNITY HEALTH

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
Full Name	Date of Birth	Phone Number(s)	Relationship to Patient	Yes | No
Full Name	Date of Birth	Phone Number(s)	Relationship to Patient	Yes | No
Full Name	Date of Birth	Phone Number(s)	Relationship to Patient	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

Acct#_______

Application for Fee Discounts

Patient Name: ____ Date of Birth: __________________

Check if Declining Discounts:

☐ *I Decline all Sliding Fee Discounts. I have received information about available discounts and understand that I can apply anytime in the future.*

List individuals who are usually, primarily, and collectively dependent upon the same Household/Family Income. All individuals included in the calculation of Household/Family Size must live together most of the time. No individual may be considered a member of more than one Household/Family.

Name and Date of Birth	Relation	Income	Week/Month/Year	Christ Community Patient? (circle)
	self			Yes
				Yes/No
				Yes/No
				Yes/No
				Yes/No
				Yes/No
				Yes/No
				Yes/No

(Continue on separate sheet if necessary)

Provide verification of income for each household member as available. If income verification is not available, please complete Self-Attestation form.

Acct#_______

Examples of income below and acceptable proof of income (only one document needed for each income source):

- Salaries & wages (pay stub, cash app, tax form, letter from employer, Self-Attestation form, etc.)
- Self-employment income (tax form, Self-Attestation form, etc.)
- Retirement, including pensions and social security (Benefit Statement, deposit receipt, etc.)
- Unemployment income (Benefit statement, pay stub)
- Workers' compensation, disability, or other related income (benefit statement, pay stub)
- Child support and alimony received (receipt, benefit statement, bank statement, court document.

If applying for discounts, I understand that by signing below I attest that this information represents my household size and income to the best of my ability. I also understand that these discounts apply only to services rendered while I have an active Sliding Fee Discount. If documentation is returned after a visit within two weeks for a new patient, two weeks of a new application, or two weeks from a renewed application, discounts will be applied up to that two-week period. Also, I understand that all applicable payments are expected at the time of service. New applicants and renewing patients (once a year) may only be required to pay a nominal fee at time of service if application for discounts is pending.

Printed Name____

Signature: ____

Date: _________________

____

Office Use Only: Approved/Not Approved

Pt Access Rep Signature: ______________________________

Printed Name: ____

ACTIVE SLIDING FEE LEVEL DATE RANGE ____

LEVEL: A B C D E

CHRIST COMMUNITY HEALTH

No-Show Policy Acknowledgement
ADULT MEDICAL and BEHAVIORAL HEALTH

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

Keeping Scheduled Appointments & Arriving Early

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

You are required to arrive 20-30 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*. Notification after 3:00 pm the business day before the appointment is too late and is considered a no-show. If you are more than 10 minutes late, we might require you to be re-scheduled. 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"?

- A no-show is someone who does not arrive for their appointment on the day of the appointment or does not notify the office before 3:00 pm the business day before the 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 two new patient medical appointments in a 12-month period, you will not be allowed to schedule another appointment for one year.

Established Patients:
If you No-Show 3 appointments in a 12-month period, you will not be allowed to schedule another appointment ahead of time for one year but must call for a same day appointment. You will be given an appointment if there are any available.

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

____ _______________________________

Patient or Patient's Parent/Guardian Signature Date