Community Health Centers of Greater Dayton

PATIENT INFORMATION REGISTRATION FORM: Complete all sections

PATIENT INFORMATION:

Last name	First Name	MI	Nickname	Social Security #	Birthdate	Sex

BILLING ADDRESS of Patient or Responsibility Party	City	State	Zip

☐ Home Phone ( )	☐ Alternate Phone ( )	☐ Family/Friend Outside Home ( )

E-Mail Address: ☐ No – Requesting Help ☐ **Refused**

RESPONSIBLE PARTY (Required for patients under 18 or whenever the guarantor is not the patient):

Last Name	First name	MI	Social Security #	Birth Date	Relationship

INSURANCE INFORMATION (Please present ALL Insurance Cards and a Picture ID to the receptionist):

Primary Insurance	Policy Holder	Date of Birth	Effective	Co-Pay $	Policy #	Relationship
Secondary Insurance	Policy Holder	Date of Birth	Effective	Co-Pay $	Policy #	Relationship

INFORMATION FOR STATISTICAL REPORTING ONLY:

Please ☑ race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native Are you Latino/Hispanic?
☐ More than One Race ☐ Native Hawaiian / Other Pacific Islander ☐ YES ☐ NO

☑ Preferred language: ☐ English ☐ Spanish ☐ French ☐ Sign Language ☐ German ☐ Russian ☐ Other:_____

☑ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced ☐ Life Partner ☐ Other:_____

☑ If you are a ☐ Veteran ☐ Smoker | ☑ If you are: ☐ Doubling Up ☐ Transitional ☐ Shelter ☐ Street

Occupation: ☐ Retired ☐ Disabled ☐ Unemployed ☐ Student ☐ Decline to answer ☐ Employed (list below what you do)

If employed tell us what you do: _____

What Advanced Directives do you have: ☐ Living Will ☐ Durable Power of Attorney ☐ None ☐ Decline to answer

If Yes, please specify who & their relation to you _____

Legal Guardian: ☐ Yes, Name_____ ☐ None

Health Care Proxy: ☐ Yes, Name_____ ☐ None

For Patients 18 and Older ONLY

Sexual Orientation: ☐ Straight or Heterosexual ☐ Lesbian, Gay or Homosexual ☐ Bisexual
☐ Something else (please specify):_____ ☐ Don't Know ☐ Decline to answer

For Patients 18 and Older ONLY

Gender Identity - Do you think of yourself as: ☐ Male ☐ Female ☐ Female-to-Male (FTM/Transgender Male/Trans Man)
☐ Male-to-Female (MTF/Transgender Female/Trans Woman) ☐ Genderqueer, neither exclusively male nor female
☐ Other / Additional gender category (please specify) _____ ☐ Decline to answer

Primary Caregiver: ☐ None/Self ☐ Yes If yes, Who: _____ Relationship: _____

I understand that it is my responsibility to provide complete and accurate information on this form. I understand that failure to provide this information may result in my being responsible for full charges.

Patient Name (Printed)	Signature of Patient/Responsible Party	Date

PATIENT RIGHTS AND RESPONSIBILITIES

As a patient of The Community Health Centers of Greater Dayton you have the following rights:

- To be treated with respect, compassion and consideration without regard to race, gender or ability to pay
- To quality heath care
- To a timely response to requests for health care services
- To know the name and qualifications of staff members providing care
- To privacy of your medical and financial records
- To make informed decisions regarding your medical treatment including the right to refuse treatment
- To request a consultation
- To see and obtain a copy of your medical records
- To request financial information regarding your account
- To designate a guardian or Power of Attorney (POA) to act on your behalf
- To an interpreter

As a patient of The Community Health Centers of Greater Dayton you have the following responsibilities:

- To maintain healthy habits
- To be respectful to all physicians, nurse practitioners, and staff members.
- To provide complete and accurate information to your physician or nurse practitioner.
- To provide a complete list of all medications you are currently taking including dosage
- To adhere to all treatment plans including correct use of prescriptions
- To contact the office for an appointment when you pick up the last refill on your prescription
- To arrive for all appointments on time and to contact the office at least 24 hours in advance if you are unable to make it
- To keep all appointments scheduled for ancillary tests or to a consulting physician
- To provide us with current and accurate information regarding your insurance carrier
- To notify your insurance carrier of any change in primary care provider
- To provide us with a copy of all insurance cards
- To complete a sliding fee scale application and to provide documentation of household income
- To notify us of any change in your income status as it relates to your sliding scale status.
- To pay all copayments and sliding scale nominal fees at time of service
- To complete a patient registration form, sliding fee scale application and associated signatures on an annual basis.
- To notify us of any change in insurance, address, telephone number, marital status

I, as a patient of the COMMUNITY HEALTH CENTERS OF GREATER DAYTON, agree to the above patient rights and responsibilities.

_____ _____

Patient Name Date

_____ _____

Signature of Patient or Guardian (if patient is a minor) Date

COMMUNITY HEALTH CENTERS OF GREATER DAYTON
WELCOME TO OUR PRACTICE

Scheduling Line: 937-461-6869 M-F 7:30 am to 5:30 pm

Please use this number to make all appointments. Also use this to cancel or reschedule any appointments.

Community Health Centers of Greater Dayton (CHCGD) is a nonprofit organization founded in 2007 to improve access to high-quality, affordable primary health care in the region. We currently operate six locations: Alex Central Health Center, Charles Drew Health Center, Corwin Nixon Health Center, East Dayton Health Center, Patterson Park Health Center and Victor Cassano Health Center.

Our Mission: Improving lives by providing quality primary and preventative healthcare services to those in need, regardless of ability to pay.

In order to assure that we submit the charges for your services to the correct insurance carrier, we ask that you present your insurance card and picture ID at each visit. If you are unsure which card is correct, please bring all cards and our staff members will assist you. **We do not accept Bureau of Workers Compensation claims.**

All patients are asked to complete a Sliding Fee Discount Application to assist us with determining if you are eligible for a fee discount and to meet our Federal funding guidelines.

You will be assigned a physician or nurse practitioner that will be your primary provider for every visit. It is our goal to be the Patient Centered Medical Home (PCMH) for all of your health care needs – this includes your urgent needs. Please contact us first for your urgent health care needs as they come up. If your assigned provider is unavailable, one of our other providers may be able to take care of your needs for that day. To reach a provider after hours, please call the center and the message will provide instructions for reaching the provider on-call.

We may at times have health professional students in our practice participating in your care. If you would prefer that students not participate in your care, please inform a member of our staff.
New patients may not request prescriptions for controlled substances on their first visit and these medications will not be routinely refilled over the phone.

Our health care providers do not provide chronic pain management; but may refer you to a health care provider specializing in these medical problems.

When you arrive for a visit, tell the medical assistant exactly why you need to see your physician or nurse practitioner and what medication refills you will need. Please bring all medications with you to your visit. When calling in to receive medication refills, it can take between twenty-four (24) and seventy-two (72) hours to complete the entire process.

Thank you for choosing CHCGD. We look forward to becoming your Patient Centered Medical Home.

COMMUNITY HEALTH CENTERS OF GREATER DAYTON
General Consent

I. GENERAL CONSENT FOR TREATMENT

A. I, the undersigned, am the patient (or the Patient's duly authorized representative) and do hereby voluntarily consent to and AUTHORIZE CARE, INCLUDING NURSING CARE AND ALL DIAGNOSTIC AND THERAPUTIC TREATMENTS CONSIDERED NECESSARY OR ADVISABLE IN THE JUDGEMENT OF THE PHYSICIAN, AND/OR HIS/HER ASSISTANTS OR DESIGNEES.

B. I consent to the performance of diagnostic testing, including the drawing of blood, in the event that Community Health Centers of Greater Dayton (CHCGD) staff member exposure to any of my body fluids. This includes HIV/AIDS testing.

II. RELEASE OF INFORMATION

A. I authorize CHCGD, by this written release, to furnish information from the patient's medical record to its agents, or any insurers, compensation carrier, healthcare facility, welfare agency or any healthcare provider for reasons of financial assistance or continuity of medial care.

B. I do not authorize disclosure of the following information (list any exclusions, information regarding drug or alcohol treatment, psychiatric treatment, AIDS, AIDS related condition, HIV testing, or diagnosis and treatment of HIV);

_____

C. I understand that other providers may render services to me while I am a patient, and may bill separately. Therefore, I AUTHORIZE ASSIGNMENT OF BENEFITS TO THOSE PROVIDERS, WHICH MAY INCLUDE RADIOLOGISTS, PATHOLOGISTS AND ANESTHESIOLOGISTS, DOCTORS WHO ARE SPECIALISTS ACTING AS INDEPENDENT CONTRACTORS AT CHCGD.

D. I authorize CHCGD to run my credit report, when I or my representative have requested that CHCGD extend credit on my account. Credit is extended when payment is not made on the day of service.

E. I authorize CHCGD to access medication records from my pharmacy as needed to provide continuity of care.

III. FINANCIAL AUTHORIZATION AND RELEASE OF INFORMATION

A. I authorize payment directly to CHCGD and/or the physicians or their designees of the benefits herein specified and otherwise payable to me but not to exceed the regular charges. I understand I am responsible for all charges until the bills are paid in full and for the balance of charges not covered by insurance.

B. MEDICARE PATIENTS ONLY – I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I authorize any holder, including the physicians and/or their designees, of medical or other information about me to release to the Social Security Administration and/or the Medicare program any information needed for this or related Medicare claim.

C. IF FOR ANY REASON MEDICARE (OR MY INSURANCE COMPANY) DENIES PAYMENT, I AUTHORIZE CHCGD TO ACT ON MY BEHALF TO APPEAL FOR PAYMENT.

D. SELF PAY PATIENTS ONLY – I understand that if I am a self-pay patient, I must pay a minimum payment prior to receiving any health care services. If an unpaid balance exists on my account after applying my discount percentage, I agree to make payment arrangements and honor the terms. I understand that if I am unable to make a payment in any given month, I must contact the center prior to the due date to discuss my need to modify my payment arrangements.

My signature, or that of my authorized representative, indicates that I have read, understand and agree with the above conditions and have provided accurate information.

_____		_____		_____	
Patient's Name	DOB	Signature of Patient or Legal Representative or Agent	Date	Witness	Date

Community Health Centers of Greater Dayton

I consent to Community Health Centers of Greater Dayton (CHCGD) using and disclosing my protected health information to carry out treatment, payment, or health care operations.

I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that CHCGD reserves the right to change their notice and information practices and that I may obtain a revised copy of the notice by requesting one from the health center.

I have the right to revoke this consent by notifying CHCGD in writing, except to the extent that CHCGD has taken action in reliance on my consent.

List names of people that doctor/nurse practitioner can talk to about your health information:

Name	Relationship	Phone Number

I understand that CHCGD will not discuss my medical care or billing information with anyone not listed on this consent.

I understand that this consent supersedes any other consent that may have been signed.

Signature of Patient or Patient's Representative	Date

Printed Name of Patient or Patient's Representative	Relationship to Patient or Authority to act on behalf of the Patient

CHCGD has my permission to leave a message on my contact phone numbers/answering machine or cell phone regarding my healthcare needs. ____Yes ____No _____initials

Community Health Centers of Greater Dayton

PARENTAL CONSENT

To allow another person to bring your child to an appointment.

We must receive permission from a child's parent or legal guardian before providing treatment for an injury or illness that is non-life threatening. This form gives our office legal permission to treat your child in case you cannot accompany your child to his/her appointment for treatment. If this information is not presented by the party accompanying your child (baby-sitter, relative, friend) we will contact the child's parent or legal guardian before treating the child.

Name of child: _____

Child's DOB: _____

I grant (*baby-sitter, relative, friend*) **Name:** _____

Phone#: _____ permission to authorize treatment and to

receive age appropriate vaccines at _____.
write in name of health center

Start date _____
(*Date*)

- ☐ Today only
- ☐ 1 year from today's date
- ☐ Other _____

Parent or Legal Guardian Signature: _____

Today's Date: _____

Child's information:

Allergies to drugs or foods: _____

Special medications: _____

Other important medical information: _____

Community Health Centers of Greater Dayton

Billing Agreement

Health Insurance:

I am aware that it is my responsibility as the patient to give a copy of my insurance card to Community Health Centers of Greater Dayton at the time of my service.

Self-Pay (Uninsured or Underinsured):

I am aware that it is my responsibility to complete a Sliding Fee Application and return my proof of income within 30 days of my visit or I will be responsible for 100% of my bill.

Co-Pay:

I am aware that my copay is my responsibility. I may pay with cash, check or credit card.

Statements:

I am aware that I will only receive two (2) statements and one (1) past due statement (a total of 3 statements) before my account may be sent to an outside collection agency. I am also aware if CHCGD receives returned mail because I have not supplied a correct/updated mailing address, I may be sent to an outside collection agency.

Payment Arrangements:

I am aware that if there is a balance due I may set the balance up on a "Payment Arrangement" if I am unable to pay in full. I am also aware that if I do not set up the payment plan with CHCGD or I do not make my scheduled payments I may be sent to an outside collection agency.

Collections:

I am aware that if I am sent to an outside collection agency two (2) times that I may be discharged from the practice and I will no longer be able to receive services at Community Health Centers of Greater Dayton.

_____ _____

Patient/Guarantors Signature Date

Community Health Centers of Greater Dayton

Community Health Centers of Greater Dayton is a federally qualified health center. We are required to collect the incomes of our patient population. All information is confidential and we are only required to report numbers not patient names.

A family size is your immediate family who live in your home that you are legally responsible for and children you pay child support for that do not live in your home.

1. Circle your family size

2. Circle your income

Family Size	Income Under	Income between	Income between	Income between	Income Over
1	$12,490	$12,491-$16,612	$16,613-$18,735	$18,736-$24,980	$24,981
2	$16,910	$16,911-$22,490	$22,491-$25,365	$25,366-$33,820	$33,821
3	$21,330	$21,331-$28,369	$28,370-$31,995	$31,996-$42,660	$42,661
4	$25,750	$25,751-$34,248	$34,249-$38,625	$38,626-$51,500	$51,501
5	$30,170	$30,171-$40,126	$40,127-$45,255	$45,256-$60,340	$60,341
6	$34,590	$34,591-$46,005	$46,006-$51,885	$51,886-$69,180	$69,181
7	$39,010	$39,011-$51,883	$51,884-$58,515	$55,516-$78,020	$78,021
8	$43,430	$43,431-$57,762	$57,763-$65,145	$65,146-$86,860	$86,861

We will ask you to update this information yearly.

Patient Name:_____ Date of Birth: _____

Today's Date: _____

Community Health Centers of Greater Dayton

New Patient History Form

Name_____ Date of Birth_____

Medication	Dose	How often	Why do you take it?	Who prescribes it?

Allergies	What happens when you take it?

Medical Problems	Please list all surgeries you have had since birth

Family History: Please list all medical problems each family member has had.

Mother	
Father	
Grandmother (mom's side)	
Grandfather (mom's side)	
Grandmother (dad's side)	
Grandfather (dad's side)	
Brother	
Sister	

Do you see any other doctors? What for?_____

Do you smoke?_____ How much?_____ Former smokers: when did you quit? _____

Do you drink alcohol?_____ How often?_____ Illegal drugs _____

Current job_____ Who lives with you?_____