Norwalk Community Health Center

NEW PATIENT REGISTRATION FORM

Patient: _____

Date : _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Gender at birth: ◯ Male ◯ Female ◯ I choose to not respond

Sex: ◯ Male ◯ Female ◯ Transgender Male (FTM) ◯ Transgender Female (MTF) ◯ Genderqueer ◯ I choose to not respond

Address: _____

City: _____ State: _____ ZIP _____

Email: _____ Cell Phone: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other

Emergency Contact: _____ Phone: _____

Relationship to Emergency Contact: _____

Race: ◯ African American ◯ Afrolatino ◯ Asian ◯ Caucasian/White ◯ Multiracial ◯ Native American/Native Alaskan/Inuit ◯ Pacific Islander ◯ Other

Ethnicity: ◯ Latin ◯ Hispanic ◯ Not Latino/Hispanic

Veteran Status: ◯ I am a veteran ◯ I am NOT a veteran

Previous Primary Care Provider: _____ Dental Office: _____

For Minors: *Parent or Legal Guardian Information:*

First Name: _____ Last Name: _____

Relationship to guardian: ◯ Mother ◯ Father ◯ Foster Parents ◯ Grandparent ◯ Legal guardian ◯ Conservator ◯ Power of Attorney ◯ Other: _____

Address: _____

City: _____ State: _____ ZIP: _____

Email: _____ Cell Phone: _____

INSURANCE INFORMATION

◯ No Insurance

◯ Primary Insurance

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

_____ _____

Patient Signature Date

GENERAL CONSENT FOR TREATMENT & BILLING

Patient: _____

Date : _____

I give Norwalk Community Health Center (NCHC) permission to provide necessary medical, behavioral health and/or dental evaluation and treatment.

1. I allow NCHC to file for insurance benefits to pay for the care received. I understand that:

- Norwalk Community Health Center may have to send my medical/dental record information to my insurance company
- I must pay my share of the costs
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance

2. I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical/dental treatments with my provider.

I declare that the information listed above is accurate and complete. I understand that I may be asked for evidence to verify the statement of income and family size.

_____

Print Patient Name/Parent or Guardian (for children under 18) *Date*

_____

Signature of Patient/Parent or Guardian (for children under 18) *Date*

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TELEMEDICINE CONSENT

Patient: _____

Date : _____

I give Norwalk Community Health Center (NCHC) permission to provide health services via telehealth

I understand that:

a. I have the right to access Norwalk Community Health Center medical services through an in-person, face-to-face visit or through telehealth.

b. The use of telehealth is voluntary, and I may withdraw my consent to,or stop receiving services through telehealth at any time without affecting my ability to access covered services in the future.

c. There may be limitations or risks related to receiving services through telehealth as compared to an in-person visit.

d. I have read this document carefully, understand the potential limitations and risks of receiving services via telehealth and have had my questions answered to my satisfaction.

e. I understand that there may be a charge associated with the visit. I understand that I will be responsible for any self pay balance, unmet deductible amount or coinsurance associated with the Telemedicine visit. *You will receive a link from Global Pay prior to your appointment allowing you to make a payment.*

f. I authorize Norwalk Community Health Center to use appropriate telecommunication technology for the purposes of evaluating and diagnosing my medical condition and any health complaints.

g. I accept that the medical professionals will attempt to contact me using telehealth software.

h. I understanding that technical issues may arise before or during the telehealth session, and on occasions, my appointment may not start or end at the agreed upon time

i. I understand that my telemedicine visit may be cancelled or rescheduled if I do not agree to the above terms and conditions.

_____

Print Patient Name/Parent or Guardian (for children under 18) *Date*

_____

Signature of Patient/Parent or Guardian (for children under 18) *Date*

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PATIENT'S BILL OF RIGHTS & RESPONSIBILITIES

Patient: _____

Date : _____

Norwalk Community Health Center (NCHC) is committed to providing high quality care that is fair, responsive, and accountable to the needs of our patients and their families. We are committed to providing our patients and their families with a means to not only receive appropriate health care and related services, but to also address any concerns they may have regarding such services. We encourage all of our patients to be aware of their rights and responsibilities and to take an active role in maintaining and improving their health and strengthening their relationships with our health care providers.

We strongly urge anyone with questions or concerns regarding our "Bill of Rights and Responsibilities" to contact the Practice Manager.

EVERY PATIENT HAS A RIGHT TO:

1. Receive high quality care based on professional standards of practice, regardless of his or her (or his or her family's) ability to pay for such services.
2. Obtain services without discrimination on the basis of race, ethnicity, national origin, sex, age, religion, physical or mental disability, sexual orientation or preference, marital status, socioeconomic status or diagnosis/condition.
3. Be treated with courtesy, consideration and respect by all NCHC staff, at all times and under all circumstances, and in a manner that respects his or her dignity and privacy.
4. Be informed of NCHC's Privacy Policies and Procedures, as the policies relate to individually identifiable health information.
5. Expect that NCHC will keep all medical information confidential and will release such information only with his or her written authorization, in response to court order or subpoenas, or as otherwise permitted or required by law.
6. Access, review and/or copy his or her medical records, upon request, at a mutually designated time (or, as appropriate, have a legal custodian access, review and/or copy such records), and request amendment to such records.
7. Know the name and qualifications of all individuals responsible for his or her health care and be informed of how to contact these individuals.
8. Request a different health care provider if he or she is dissatisfied with the person assigned to him or her by NCHC. NCHC will use best efforts, but cannot guarantee, that re-assignment requests will be accommodated.
9. Receive a complete, accurate, easily understood, and culturally and linguistically competent explanation of (and, as necessary, other information regarding) any diagnosis, treatment, prognosis, and/or planned course of treatment, alternatives (including no treatment), and associated risks/benefits.
10. Receive information regarding the availability of support services, including translation, transportation and education services.

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PATIENT'S BILL OF RIGHTS & RESPONSIBILITIES

Patient: _____

Date : _____

11. Receive sufficient information to participate fully in decisions related to his or her health care and to provide informed consent prior to any diagnostic or therapeutic procedure (except in emergencies). If a patient is unable to participate fully, he or she has the right to be represented by parents, guardians, family members or other designated surrogates.
12. Ask questions (at any time before, during or after receiving services) regarding any diagnosis, treatment, prognosis and/or planned course of treatment, alternatives and risks, and receive understandable and clear answers to such questions.
13. Refuse any treatment (except as prohibited by law), be informed of the alternatives and/or consequences of refusing treatment, which may include Norwalk Community Health Center having to inform the appropriate authorities of this decision, and express preferences regarding any future treatments.
14. Obtain another medical opinion prior to any procedure.
15. Be informed if any treatment is for purposes of research or is experimental in nature, and be given the opportunity to provide his or her informed consent before such research or experiment will begin (unless such consent is otherwise waived).
16. Develop advance directives and be assured that all health care providers will comply with those directives in accordance with law.
17. Designate a surrogate to make health care decision if he or she is or becomes incapacitated.
18. Ask for and receive information regarding his or her financial responsibility for the services.
19. Receive an itemized copy of the bill for his or her services, an explanation of charges, and description of the services that will be charged to his/her insurance.
20. Request additional assistance necessary to understand and/or comply with NCHC administrative procedures and rules, access health care and related services, participate in treatments, or satisfy payment obligations by contacting the Chief Operating Officer.
21. File a grievance or complaint about NCHC or its staff without fear of discrimination or retaliation and have it resolved in a fair, efficient and timely manner. This grievance or complaint can be directed to Chief Administrative Officer.
Contact the following agency if you are not satisfied with the outcome of your grievance:

NCHC's Confidential Compliance Line:
203-852-3999

Connecticut Department of Public Health
410 Capital Avenue
Hartford, CT. 06134-308
Phone: (860) 509-7400, (800) 842-0038 TTY: (860) 509-7191
www.dph.state.ct.us

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PATIENT'S BILL OF RIGHTS & RESPONSIBILITIES

Patient: _____

Date : _____

EVERY PATIENT IS RESPONSIBLE FOR:

1. Providing accurate personal, financial, insurance, and medical information (including all current treatments and medications) prior to receiving services from NCHC and its health care providers.
2. Following all administrative and operational rules and procedures posted within NCHC facilities.
3. Behaving at all times in a polite, courteous, considerate and respectful manner to all NCHC staff and patients, including respecting the privacy and dignity of other patients.
4. Supervising his or her children while in NCHC facilities.
5. Refraining from abusive, harmful, threatening, or rude contact towards other patients and NCHC staff.
6. Not carrying any type of weapons or explosives into NCHC facilities.
7. Keeping all scheduled appointments and arriving on time.
8. Notifying NCHC no less than 24 hours (or as soon as possible within 24 hours) prior to the time of an appointment that he/she cannot keep the appointment as scheduled. Failure to follow this policy may result in being charged for the visit and/or being placed on a waiting list for the next visit.
9. Participating in and following the treatment plan recommended by his or her health care providers, to the extent he or she is able, and working with providers to achieve desired health outcomes.
10. Asking questions if he or she does not understand the explanation of (or information regarding) his or her diagnosis, treatment, prognosis, and/or planned course of treatment, alternatives or associated risks/benefits, or any other information provided to him or her regarding services.
11. Providing an explanation to his or her health care providers if refusing to (or unable to) participate in treatment, to the extent he or she is able, and clearly communicating wants and needs.
12. Informing his or her health care providers of any changes or reactions to medication and/or treatment.
13. Familiarizing himself or herself with his or her health benefits and any exclusions, deductibles, co-payments, and treatment costs.
14. As applicable, making a good faith effort to meet financial obligations, including promptly paying for services provided.
15. Advising NCHC of any concerns, problems, or dissatisfaction with the services provided or the manner in which (or by whom) they are furnished.
16. Utilizing all services, including grievance and complaint procedures, in a responsible, non-abusive manner, consistent with the rules and procedures of NCHC (including being aware of NCHC's obligation to treat all patients in an efficient and equitable manner).

If you would like a copy of the Patient's Bill of Rights in another language, please ask the front desk staff.
Si desea una copia de la Declaración de Derechos del Paciente en otro idioma, consulte al personal de la recepción.
Si ou ta renmen yon kopi Dwa Pasyan an nan yon lòt lang, tanpri mande anplwaye nan biwo devan.

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Norwalk Community Health Center

NOTICE OF PRIVACY PRACTICES

Patient: _____

Date : _____

HIPAA NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerns or objections to this form, please ask to speak with our Director of Quality, Risk & Compliance.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

necessary service to you. No medical information is provided. We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

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Norwalk Community Health Center

ACKNOWLEDGEMENT OF RECEIPT

Patient: _____

Date : _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____

By signing this form, I am acknowledging that:

- I am either the patient or the patient's legal guardian or personal representative;
- I have received a copy of the "Notice of Privacy Practices" for Norwalk Community Health Center, Inc.;
- I have received the Norwalk Community Health Center's Patient's Bill of Rights in a language I can understand;
- I understand that I may contact Norwalk Community Health Center Inc. at any time in the future if I have questions about the content of the Notice of Practice and/or the Patient's Bill of Rights.

Please sign and date this acknowledgement form.

_____

Print Patient Name/Parent or Guardian (for children under 18) Date

_____

Signature of Patient or Parent/Guardian (for children under 18) Date

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PATIENT FINANCIAL RESPONSIBILITY FORM

Patient: _____

Date : _____

1. Individual's Financial Responsibility

- I understand that I am financially responsible for my medical, behavioral health and/or dental insurance deductible, copay and non-covered service.
- Co-payments are due at the time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my medical, behavioral health and/or dental insurance determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to meet with an eligibility counselor to determine if I qualify for the sliding fee scale discount program

2. Insurance Authorization for Assignment of Benefits

- I hereby authorize and direct payment of my medical, behavioral health and dental benefits to Norwalk Community Health Center, Inc. on my behalf for any services furnished to me by the providers.

3. Authorization to Release Records

- I hereby authorize Norwalk Community Health Center Inc. to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. Medicare Request for Payment

- I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Norwalk Community Health Center Inc. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

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