

New Patient Registration Form

As a Federally Qualified Health Center, Roanoke-Chowan Community Health Center is required to collect demographic information regarding the patients we serve. The information you provide is confidential. Please check Not Reported/Refused if you do not wish to answer a specific question. Thank you for choosing RCCHC as your health care provider.

Section 1: Patient Information

First Name: _____ **Middle Name:** _____ **Last name:** _____
Suffix: _____ **Social Security Number:** _____ **Sex:** Male Female
Date of Birth: _____ **Marital Status:** Single Married Other _____
Street Address: _____ **City:** _____
State: _____ **Zip Code:** _____ **Email:** _____ **Primary Phone:** Home Cell Work
Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____
How did you learn about RCCHC? Friend/Family referral Physician referral Phone Book
 Online Newspaper Advertisement Radio Advertisement Other _____
Primary Language: English Spanish Sign Language Other _____
Race: American Indian or Alaska Native Asian African American Caucasian Native Hawaiian or
 Other Pacific Islander Other _____
Ethnicity: Latino/Hispanic Non-Latino/Hispanic Not Reported/Refused
Gender Identity: Not Reported/Refused Female Male Transgender Female (Male-to-Female)
 Transgender Male (Female-to-Male) Non-Binary (Identifying as any gender other than female or male)
 Uncertain Other _____
Sexual Orientation: Not Reported/Refused Heterosexual/Straight Homosexual/Gay/Lesbian Bisexual
 Uncertain Other _____

Section 2: Guarantor (Financially Responsible Individual) Information

Guarantor is: Patient is Guarantor (no need to complete rest of this section) Person Company
Patient's Relation to Guarantor: Child Parent Spouse Employer Other _____
First Name: _____ **Middle Name:** _____ **Last name:** _____
Suffix: _____ **Social Security Number:** _____ **Sex:** Male Female
Date of Birth: _____ **Marital Status:** Single Married Other _____
Street Address: _____ **City:** _____
Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____
Primary Language: English Spanish Sign Language Other _____

Section 3: Family Income and Shelter Information

We request income on all patients for governmental reporting purposes.
If eligible for the Sliding Fee Scale, please complete separate Sliding Fee Application.

Income Period: Weekly Bi-weekly Monthly Bi-monthly Quarterly Annually Other _____

Gross Income for Period: \$ _____ Number of Individuals Income Supports: ____ Disabled: Yes No

Homeless Status: Not Homeless Homeless Shelter Transitional Doubling Up Street Other _____

Worker Status: Migrant Not Migrant Seasonal Veteran: Yes No

Section 4: Patient Insurance Information

Please allow our staff to copy/scan your insurance card.

Plan 1 Information

Insurance Company: _____

Group Number: _____ Claim Member ID: _____

Use Patient Information (no need to complete the rest of this section)

Patient's Relation to Subscriber: Child Parent Spouse Other _____

First Name: _____ Middle Name: _____ Last name: _____

Suffix: _____ Social Security Number: _____ Sex: Male Female

Date of Birth: _____ Street Address: _____ Apartment Number: _____

City: _____ State: _____ Zip Code: _____ Phone Number: _____

Plan 2 Information

Insurance Company: _____

Group Number: _____ Claim Member ID: _____

Use Patient Information (no need to complete the rest of this section)

Patient's Relation to Subscriber: Child Parent Spouse Other _____

First Name: _____ Middle Name: _____ Last name: _____

Suffix: _____ Social Security Number: _____ Sex: Male Female

Date of Birth: _____ Street Address: _____ Apartment Number: _____

City: _____ State: _____ Zip Code: _____ Phone Number: _____

Section 5: Alternative Contact Authorization

This authorization allows Roanoke Chowan Community Health Center Providers and staff to communicate information regarding your medical care to the individual(s) you designate. As part of RCCHC's Patient Privacy Policy, RCCHC will release your health information only as you specifically authorize. Please check whether you do or do not authorize RCCHC to release your health information and complete the form.

- I do not authorize anyone to receive information regarding my medical care.
- I do authorize the Providers and staff of this RCCHC practice to release information regarding my medical care with the individual(s) listed below.

Contact #1

Name: _____ **Relationship:** _____ **Phone:** _____

- Emergencies Only Appointments Financial Account Test Results All Information
- Other: _____

Contact #2

Name: _____ **Relationship:** _____ **Phone:** _____

- Emergencies Only Appointments Financial Account Test Results All Information
- Other: _____

Contact #3

Name: _____ **Relationship:** _____ **Phone:** _____

- Emergencies Only Appointments Financial Account Test Results All Information
- Other: _____

Section 6: Preferred Pharmacy

Pharmacy Name: _____ **Phone Number:** _____ **City:** _____ **State:** _____

Section 7: Consent to Treat Minor

The Minor Treatment Consent Form gives our providers permission to treat your child when he or she is in someone else's care. Please list the person's name, phone number, and his or her relationship to your child in the spaces provided.

I, _____, the legal parent/guardian of _____ (Minor's Name), grant permission to the following individual(s) to request and approve medical care for the above named minor:

Name: _____ **Relationship to Child:** _____ **Phone:** _____

Name: _____ **Relationship to Child:** _____ **Phone:** _____

Name: _____ **Relationship to Child:** _____ **Phone:** _____

Name: _____ **Relationship to Child:** _____ **Phone:** _____

Parent/Legal Guardian Signature

Date

NeoHealth Witness Signature

Date

Treatment and Payment Authorization

You are responsible for your own bill. As a courtesy, RCCHC will submit charges to your insurance carrier. If you have no insurance, you will be required to set up payment arrangements with our financial counselor.

- I hereby assign, transfer, and set over to RCCHC all of my rights, title, and interest to my medical reimbursement benefit under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I, revoking said authorization, give written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.
- I, the undersigned, agree to participate in clinical interviews, treatment, and testing as a patient of RCCHC.
- I authorize treatment for my identified minor or myself. I also understand that examination and treatment may be by a student, intern, or resident under the supervision of a clinician.

Patient/Guardian Signature

Date

Notice of Privacy Practices

I have been given, read, and understand the Notice of Privacy Practices of RCCHC.

I have refused my copy of the Notice of Privacy Practices.

Patient/Guardian Signature

Date

Witness Signature

Date



Acknowledgment of Receipt RCCHC Welcome Packet

Please initial beside each item that you have received in writing and understand the items contained in the welcome packet. If you at any time have questions please ask for assistance from our front desk employees.

_____ Billing, Payment, and Referral Information and Registration

_____ Patient Rights and Responsibilities

_____ Medication Policy

_____ Consumer Notice of Health Information Practices (HIPAA)

_____ Notice of Privacy Practice

_____ RCCHC Sliding Fee Scale Application

Patient or Patient's Representative Signature

Date

Please Print Your Name

Patient's Name

Representative's Relationship to Patient

_ Verification Signature – RCCHC Staff

Date

For Office Use only

Patient # _____



AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

This authorization is for use or disclosure of protected health information pertaining to:

Name: _____ **Date of Birth:** _____
Address: _____
Phone #: _____

I hereby authorize the following health care provider:
Name: Ahoskie Comprehensive Care-Pediatric Dept.
Address: 120 Health Center Drive Ahoskie, NC 27910
Phone: 252-332-3548 Fax: 252-209-0848

To release my protected health information to:

Name: _____
Address: _____
Fax #: _____ **Phone #:** _____

Purpose of disclosure:
 Changing Physicians Continuing Care At my (patient) request Workers' Compensation Legal
 Second Opinion Insurance School Other _____

Protected health information to be released:
 Medical records (specify, can state "all"): _____
 Billing records X-ray report Consultation report Other _____
Time frame: entire record records from _____ (date) to _____ (date)

Your specific permission is required to disclose information regarding the following:
Check box and sign to specify protected health information to be disclosed
 Treatment by Mental Health Professional or Program _____
[Note to practice: this includes records generated at a mental health agency/facility or by a psychiatrist, clinical nurse Specialist, social worker or psychologist; records created by other physicians do not require specific authorization]
 Drug/Alcohol Abuse _____
[Note to practice: this includes records generated by medical personnel whose primary function is providing alcohol or drug abuse diagnosis, treatment, or referral and who are identified as such providers, not general care providers]
 HIV Test Results or Status _____

Roanoke Chowan Community Health Center

Expiration: This authorization becomes effective immediately and shall expire on: _____.
If no date is given, this authorization is valid for **24 months** from signature date.

- I understand that I am not required to sign this form and Roanoke Chowan Community Health Center will not condition treatment, payment for services, or eligibility for services on whether I sign this form.
- I understand that PHI released pursuant to this authorization may include records generated by another healthcare provider or facility.
- I understand that I have the right to withdraw my authorization at any time except to the extent that action has been taken in reliance on this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer at *Roanoke Chowan Community Health Center, 120 Health Center Drive Ahoskie, NC 27910*.
- I understand that PHI used or disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer be protected by confidentiality laws.
- I understand that PHI that includes alcohol or drug program information protected by federal law will require notice to the person receiving the information that it may not be shown to or shared with others without my express written permission.
- I understand that I have a right to receive a copy of this authorization.

Signed: _____ **Date:** _____

Print name: _____

If signed by other than patient, description of legal authority to act for the individual:

Identification Presented _____ Staff Initials _____

Revised May 22, 2017

Roanoke Chowan Community Health Center (RCCHC)
120 Health Center Drive
Ahoskie, NC 27910

Phone (252) 209-0237
Fax (252) 332-1665
www.rcchc.org

Parental/Guardian Proxy Access to a Child's MyChart Record

RCCHC provides access to a child's electronic health information in MyChart to parents or legal guardians for children at or under the age of 11 years old. To sign up to access your child's MyChart record, please complete this parental/legal guardian proxy authorization form and return it to RCCHC. This form is an authorization that will permit RCCHC to release your child's medical information to you via MyChart. This form should be completed by the parent or legal guardian who is authorizing RCCHC to allow parental access to their child's MyChart electronic record. This form must include the parent or legal guardian's name and information, and the child's name and information.

Child/Patient Name (*last, first, middle initial*) _____

Child/Patient Mailing Address: _____

Child/Patient Date of Birth: MM/DD/Year: _____

I am requesting that I, _____ (*insert printed name of parent or legal guardian*) receive proxy access to my child's electronic health information that is available in my child's MyChart electronic record. I understand that MyChart contains a portion of my child's medical record and that MyChart does not reflect the complete contents of the medical record. I authorize RCCHC to release the health information contained in my child's MyChart record to me. I understand that the medical information in MyChart is obtained from my child's electronic medical record and that it may include information from facilities listed in RCCHC's Notice of Privacy Practices. **Information in MyChart may include pregnancy, STD treatment, reproductive health care, alcohol and/or substance abuse treatment, genetic testing, mental health or HIV related information, such information may only be included in your child's MyChart record if permitted by state law.**

This form does not authorize release of my child's medical record to anyone else by other methods or in other ways.

Participation in MyChart and designating a parent/guardian MyChart proxy is completely voluntary. Access to my child's MyChart electronic record is solely at my request. I understand that I am not required to designate a parental MyChart proxy for my child's record, and I am not required to request MyChart access authorization for any other person. I also understand that RCCHC does not condition any of my child's health care treatment, payment or other services on whether or not I provide this parent proxy authorization. However, I also understand that if I do not provide this MyChart authorization, RCCHC will not provide me with access to my child's MyChart record. I understand that once I receive access to my child's MyChart records any redisclosure by me of the information contained in such records may not be protected by federal privacy protections.

This authorization will expire when my child reaches 12 years of age or when I request that RCCHC remove my access. I understand that RCCHC may remove my access to my child's electronic record at any time and will do so as required pursuant to state law. I understand that I may revoke this authorization at any time prior to my child's 12th birthday, by providing a written request for revocation to RCCHC. I understand that if I revoke this authorization, my access to my child's MyChart record will be ended. I also understand my revocation will not affect any disclosures that were made prior to processing the revocation request. I certify that I am the parent or legal guardian of the child listed above and that all information provided is correct. I hereby request access to my child's MyChart electronic record. I have been provided a copy of this authorization.

Signature of Parent or Legal Guardian: _____

Relationship to the Patient: _____

Date: MM/DD/Year _____

Printed Name of Parent or Authorized Representative: _____

Parent or Legal Guardian's Mailing Address: _____

If a person other than the parent or legal guardian signs this form, indicate their legal authority to sign for patient, and attach any documentation:

Ahoskie Comprehensive Care: 252-332-3548; Colerain Primary Care 252-356-2404;
Creswell Primary Care 252-797-0135; Murfreesboro Primary Care 252-398-3323 Woodland Primary Care 252-587-3511