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 Roanke 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 # _____________

RCCHC
Roanoke Chowan Community Health Center

Consent to Treat a Minor without a Parent or Legal Guardian Present

For established patients 16 years of age and older:
They can be seen for follow up appointments without a Parent or Legal guardian only if the Parent or Legal guardian fills out and signs this consent form. This form authorizes RCCHC to give treatment to their teen. The provider still has the right to reschedule the appointment if they believe the parent or legal guardian should be at the visit.

_______ I hereby permit my teen (who is 16 years or older) to be seen at RCCHC when they arrive at the office alone.

Consent

I have read and fully understand this consent for treatment. By signing below, I consent to medical treatment.
This consent will remain valid and enforceable (do what it allows) until it is revoked (canceled) or replaced by a new form of consent.

______________________________   ____/____/____

Signature of Parent or Legal Guardian   Date

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

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

Adult Proxy Access to a Teen's MyChart Record

This form is an authorization that will permit RCCHC to release your medical information to your designated adult proxy. This form should be completed by the patient who is authorizing an adult to access medical information in his or her MyChart electronic record. This form must include the name and information of the patient and the individual who the patient is authorizing to access their MyChart record as a proxy.

Patient Name (*last, first, middle initial*) ______________________________

Patient Address: ______________________________

Patient Date of Birth: MM/DD/YEAR ______________________________

I am requesting that ______________________________ ***(insert printed name of proxy)*** whose

address is: ______________________________***(insert printed address of proxy)***

be allowed to have access to my health information that is available in my MyChart electronic record. This person is my designated MyChart proxy. I authorize RCCHC to release the health information contained in my electronic MyChart record to my proxy. I understand that the medical information in MyChart is obtained from my electronic medical record and may include information from facilities listed in RCCHC's Notice of Privacy Practices. I understand that MyChart contains a portion of my medical record and that MyChart does not reflect the complete contents of the medical record. **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.**

I authorize release of my health information only through my electronic MyChart record. This form does not authorize release of my medical record to my designated proxy by other methods or in other ways. I understand that once information has been disclosed, it could be re-disclosed by the proxy, and the disclosed information may not be protected by federal privacy protections.

Participation in MyChart and designating a MyChart proxy is completely voluntary. Access to my MyChart electronic record is solely at my request. I understand that I am not required to designate a MyChart proxy and I am not required to provide MyChart access authorization to any other person. I also understand that RCCHC does not condition any of my health care treatment, payment or other services on whether I provide this authorization. However, I also understand that if I do not provide this authorization, RCCHC is not permitted to provide access to my MyChart record to my designated proxy.

This authorization will expire only when I revoke my permission for my proxy to access my information through MyChart. I understand that I also may revoke this authorization at any time by providing a written request for revocation to RCCHC I understand that if I revoke this authorization, my designated proxy's access to my MyChart record will end. I also understand my revocation will not affect any disclosures that were made prior to processing the revocation request and that any redisclosures made by the proxy may no longer by covered by federal privacy protections. I have been provided a copy of this authorization.

Signature of Patient (or authorized representative): ______________________________

Date: MM/DD/Year ______________________________

Printed Name: ______________________________

If a person other than the patient signs this form, indicate their legal authority to sign for patient (e.g., legal guardian) and attach documentation:

____

NOTE: Authorization will only expire when I revoke my permission for my proxy to have access to my information through MyChart, or when RCCHC **is notified of my death. I may deactivate the access of the adult proxy specified above by providing a written request to RCCHC.**

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 ______________

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- Continued On Back-

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:

____

Revised May 22, 2017

Identification Presented ____________________________ Staff Initials____________