COMPASSION HEALTH CARE

- Email: info@compassionhealthcare.org
- Web: compassionhealthcare.org

Caswell Family Medical Center
439 US Hwy 158 West
Yanceyville, NC 27379

- Tel: (336) 694-9331
- Fax: (336) 694-7511

James Austin Health Center
207 E Meadow Rd, # 6
Eden, NC 27288

- Tel: (336) 864-2795
- Fax: (336) 864-2895

PATIENT REGISTRATION FORM

(Updated 5/23/2022)

Patient Information

❑Dr. ❑Miss ❑Mr. ❑Mrs. ❑Ms. ❑Sir

Name: (Last) _____ (First) _____ (MI) ___ (Previous)_____

Email: _____

Address: _____ City: _____ ST: ____ Zip: _____

Phone: (Home): _____-_____-_____ (Cell): _____-_____-_____ (Work): _____-_____-_____

Do you have a preference for a particular Provider? If so, who would you like to see? _____

If your Primary Care Provider (PCP) is not CHC, please complete the following:

PCP Name: _____

Practice Name: _____

PCP Phone Number: (_____) _____-_____

Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____

Sexual Orientation: ❑Lesbian, gay or homosexual ❑Straight or heterosexual ❑Bisexual ❑Do not know ❑Choose not to disclose ❑Something else, please describe: _____

Gender Identity: ❑Male ❑Female ❑Female-to-male (FTM)/Transgender Male/Trans Man ❑Male-to-Female (MTF)/Transgender Female/Trans Woman ❑Genderqueer, neither exclusively male nor female ❑Choose not to disclose

❑Additional gender category or other, please specify: _____

❑Transgender

Marital Status: ❑Married ❑Single ❑Divorced ❑Widowed ❑Legally Separated ❑Partner

Employment Status: ❑Full Time ❑Part Time ❑Not Employed ❑Self Employed ❑Retired ❑Active Military Employer Name (If Applicable): _____

Student Status: ❑Full Time ❑Part Time ❑Not a Student

Race: ❑American Indian/Alaska Native ❑Asian ❑Native Hawaiian/Pacific Islander ❑Black/African American ❑White ❑Other ❑Declined

Ethnicity: ❑Hispanic/Latino ❑Not Hispanic/Latino ❑Declined

Language: ❑English ❑Spanish ❑Indian ❑Japanese ❑Chinese ❑Korean ❑Other: _____

Email Address: _____

What pharmacy do you use?: _____

Housing Status: ❑Homeless ❑Doubling Up ❑Private Residence ❑Group Home ❑Nursing Home

Are you disabled? ❑Yes ❑No Are you a veteran? ❑Yes ❑No

Do you have an Advanced Directive (living will, DNR, etc.)? ❑Yes ❑No

Emergency Contact:

Name: (Last) _____ (First) _____ Phone: _____ - _____ - _____

Emergency Contact Relationship to Patient: _____

Address: _____ City: _____ ST: ____ Zip: _____

Phone (Home): _____ - _____ - _____ (Cell): _____ - _____ - _____ (Work): _____ - _____ - _____

Caregiver's Information (if applicable):

Name: (Last) _____ (First) _____ Phone: _____ - _____ - _____

Caregiver's relationship: ❑Legal Guardian ❑Power of Attorney ❑Other

CERTIFICATION:

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Guardian) Signature: _____ **Date:** _____ **/** _____ **/** _____

NOTICE OF AUTHORIZATIONS & ASSIGNMENT OF BENEFITS

Assignment of Insurance Benefits: I HEREBY AUTHORIZE DIRECT PAYMENT OF INSURANCE BENEFITS TO COMPASSION HEALTH CARE, INC. or the physician individually for services rendered to my dependents, or me, by the physician or those under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Compassion Health Care, Inc. is unable to collect from my insurance carrier, for whatever reason.

Authorization to release non-public information: I certify that I have read and been offered a copy of the Compassion Health Care, Inc. HIPAA Notice of Privacy Practices, as well as receipt of Compassion Health Care, Inc.'s Office Practices and Patient Rights & Responsibilities. I hereby authorize Compassion Health Care, Inc. and/or the physician individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits. Compassion Health Care, Inc. reserves the right to revise its Notice of Policy Practices, Office Practices and Patient Rights and Responsibilities at any time. A copy of such revisions will be available upon request.

Medicare/Medicaid Information: I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits may be made directly to Compassion Health Care, Inc. or they physician on my behalf.

Lab Testing: I understand that I may receive a separate bill if my medical care includes lab services. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by my insurance for whatever reason.

Prescriptions: I acknowledge that my treating physician/medical provider may obtain a prescription history if it is deemed necessary.

Consent to Treatment: I hereby consent to evaluation, testing and treatment as directed by my Compassion Health Care, Inc. physician or those under his/her supervision.

My signature below certifies that I have read and agree to all of the information stated above.

Patient (or Guardian) Signature: _____ **Date:** _____ **/** _____ **/** _____

Do you wish to enroll for access to your medical records via CHC's patient portal? ❑Yes ❑No

**Note: When we enroll you, you will receive an email at the address you gave us on the first page of this form. You are strongly encouraged to use an email address that only you have access to.*

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Patient Medical History Information

Patient Name: _____ Date of Birth ___ / ___ / _____

Please list all allergies, including medicines, foods, environmental and betadine: _____

_____

Date Form Completed: _____ / _____ / _____

Do you have, or have you had, any of the following health conditions? (Please check all that apply)

❑Diabetes (Sugar)
❑High Blood Pressure
❑Asthma/Emphysema
❑Heart Attack
❑Heart Disease
❑Stroke
❑Tuberculosis
❑Cancer
❑Seizures
❑Glaucoma
❑Kidney Disease
❑Kidney Stones
❑Arthritis
❑Osteoporosis
❑Mental Illness
❑Alcoholism

❑Hay Fever
❑Pneumonia
❑Broken Bones
❑Phlebitis
❑Skin Disease
❑Gout
❑Rheumatic fever
❑German Measles
❑Chicken Pox
❑Hepatitis
❑Peptic Ulcer
❑Vaginal Infection
❑Sexually Transmitted Disease (STD)
❑Anemia
❑High Cholesterol
❑Blood Transfusion

❑Other (Please Describe): _____
_____
_____
_____

Please check the box for any family members listed that have had any of the following health problems.

	Father	Mother	Grandfather	Grandmother	Brother	Sister
Diabetes (Sugar)	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑
Asthma/Emphysema	❑	❑	❑	❑	❑	❑
Heart Attack	❑	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑	❑
High Cholesterol	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Tuberculosis	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Seizures	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑
Kidney Stones	❑	❑	❑	❑	❑	❑
Arthritis	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑
Alcoholism	❑	❑	❑	❑	❑	❑
Other: _____	❑	❑	❑	❑	❑	❑

Continue on next page…

Have you had any of the following surgeries? (Please check all that apply)

❑Tonsils/Throat	❑Thyroid	❑Ear	❑Eye	❑Stomach
❑Gall bladder	❑Appendix	❑Colon	❑Kidney	❑Hernia
❑Bone	❑Prostate	❑Circumcision	❑Vasectomy	❑Heart
❑Lung	❑Breast	❑Hysterectomy	❑C-Section	❑Ovaries
❑Tubal Ligation	❑Other: _____			

Social History (Please check all that apply):

❑Alcohol Use (any type) ❑Tobacco use (any type) ❑"Street" Drug Use (any type)

Female Patients Only:

What year was your last delivery? _____ Period/Menstrual Cycle: ❑Regular ❑Irregular

First day of last period (date): _____ / _____ / _____

Total # Pregnancies: _____ Total # Live Births: _____ Total # Miscarriages/stillbirths: _____ Total # abortions: _____

Please list all current medications, including birth control and over the counter medications:

_____

_____

_____

Do you have any of the following symptoms or conditions? (Please check all that apply)

General Symptoms:	❑Fatigue	❑Fever/Chills	❑Headaches	❑Loss of Appetite
Eyes:	❑Discharge	❑Burning/Itching	❑Eye Pain	❑Loss/Blurred Vision
Ears, Nose & Throat:	❑Ear Pain	❑Sinusitis	❑Nasal Discharge	❑Sore Throat
Cardiovascular:	❑Chest pain at rest ❑Shortness of breath while lying down ❑Palpitations		❑Chest pain during strenuous activities ❑Swelling of ankles	
Respiratory:	❑Coughing	❑Wheezing	❑Shortness of Breath	❑Snoring
Gastrointestinal:	❑Nausea ❑Blood in Stool	❑Vomiting ❑Abdominal Pain	❑Diarrhea ❑Heartburn	❑Constipation
Genitourinary:	❑Painful Urination	❑Frequency Urinating	❑Blood in Urine	
Musculoskeletal:	❑Back Pain	❑Neck Pain	❑Joint Pains	❑Muscle Pain
Integumentary:	❑Skin rashes	❑Changes in moles		
Neurological:	❑Blackouts ❑Seizure Activity	❑Tingling	❑Paresthesia/Numbness	❑Local weakness
Psychiatric:	❑Anxiety	❑Depression	❑Moodiness	
Endocrine:	❑Excessive Thirst	❑Change in Weight		
Hematologic/Lymphatic:	❑Abnormal Bleeding	❑Anemia		

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Disclosure of Protected Health Information

Patient Name: _____ Date of Birth ___ / ___ / _____

HIPAA (The Health Insurance Portability and Accountability Act) gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method. In order to protect the privacy and confidentiality of your information, please complete the following. This form will tell us how you wish to be contacted and with whom we may discuss your healthcare, insurance and billing questions.

CHC may contact me at the following phone numbers:

Home: (_____) _____ - _____ Cell: (_____) _____ - _____ Work: (_____) _____ - _____

CHC has my permission to leave a fully detailed message at: ❑Home ❑Cell ❑Work

CHC has my permission to leave a 'minimum necessary' message at: ❑Home ❑Cell ❑Work

This authorization permits the disclosure of protected health information that includes, but is not limited to, test results, diagnosis, treatment and billing information. This information includes mental illness or developmental disability, psychotherapy notes, HIV/AIDS testing or treatment (including information regarding test order, performance, or results, regardless if the results were positive or negative), sexually transmitted disease, substance abuse, abused of an adult with a disability, sexual assault, child abuse or neglect, genetic testing.

I hereby authorize that the protected health information regarding the above-named person may be discussed with me or the following person(s):

_____ _____
Name *Relationship*

_____ _____
Name *Relationship*

CHC will continue to communicate with you according to your above response(s) until you change your preferences. We will continue to leave appointment confirmations on your primary phone number. You can make a change by completing a new form. By signing below, you grant permission to the communication outlined above.

_____ _____
Patient Signature *Date*

_____ _____
Signature of Parent/Legal Gaurdian/Personal Representative (Required if patient is not legally Authorized to sign this form). *Relationship to the Patient*

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Sliding Fee Application

Please note: Only complete this form if you are in need of financial assistance to help cover your out of pocket health care costs. If this does not apply to you, please skip this form.

Name: (Last) _____ (First) _____ (MI) ____ (Previous) _____

Date of Birth: ____ / ____ / _____ Total Number in Household (including self): _____

Please complete the following information for the other members of your household:

	Name	Date of Birth	Also a CHC Patient?
1		___/___/_____	❑Yes ❑No
2		___/___/_____	❑Yes ❑No
3		___/___/_____	❑Yes ❑No
4		___/___/_____	❑Yes ❑No
5		___/___/_____	❑Yes ❑No
6		___/___/_____	❑Yes ❑No

Please complete the following based on income for everyone listed above:

Income Source	Monthly Amount	Income Source	Monthly Amount
Salary	$_____	Unemployment	$_____
Social Security	$_____	Pension/Retirement	$_____
Rental Income/Dividends	$_____	Interest	$_____
Spousal Support	$_____	Child Support	$_____
Foster Care	$_____	Disability	$_____
Other: _____	$_____	Other: _____	$_____

Total Monthly Income from All Sources: $_____

Please attach proof/verification for each of the income sources indicated above.

☐ *No Source of Income: How are you supporting yourself?* _____

Signature: I hereby certify that the above information concerning my income is true and complete and that I have no income other than that listed above. If I am stating I have no income, this letter serves as a "Self-Declaration" indicating that I have no income from any sources. I understand that I am responsidble for my co-pay once I qualify for Sliding Fee. I promise to notify CHC at once if there is a change in my income, family size, mailing address, or telephone number.

_____ _____ / _____ / _____

Patient Signature Date

For office use only:

I have reviewed the application and determined that the patient:
❑ is not eligible for sliding fee scale.
❑ is eligible and has been assigned to: ❑ Slide A ❑ Slide B ❑ Slide C ❑ Slide D ❑ Slide E

Staff Signature: _____ Date: ___ / ___ / _____

Verification: _____ **Effective Dates:** From ___ / ___ / _____ To ___ / ___ / _____