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


# Patient Registration Form

(Revised 8/16/2023)

**Demographics:**

Last Name: ______________________________________________ First Name: ___________________________________ MI: _____

Preferred Name: ___________________________________________

Address: _____________________________________________________________________________________

City: ___________________________________________________ State: _______ Zip Code: _______________

Date of Birth: ______/______/_________ Birth Sex: _______________________________

Home Phone Number: ________-________-___________ Cell Phone Number: ________-________-___________

Email Address: _______________________________________________________

**The following information is collected to help us better meet the needs of our patients. As a federally supported Community Health Center, we report compiled data for our patient population, but individual information is not reported.**

**Sexual Orientation (If aged 18 or older)**

- Lesbian/Gay/Homosexual ☐
- Straight/Heterosexual ☐
- Bisexual ☐
- Do not know ☐
- Choose not to disclose ☐

**Current Gender Identity (If aged 18 or older)**

- Male ☐
- Female ☐
- Transgender Male (Female to Male) ☐
- Transgender Female (Male to Female) ☐
- Genderqueer (Neither Male nor Female) ☐
- Choose not to disclose ☐

**Race:**

- Asian ☐
- Native Hawaiian or other Pacific Islander ☐
- Black/African American ☐
- American Indian/Alaska Native ☐
- White ☐
- Other Race (specify): _______________ ☐
- Choose not to disclose ☐

**Ethnicity:**

- Hispanic ☐
- Non-Hispanic ☐
- Choose not to disclose ☐

Are you a Veteran of Military Service: __ Yes __ No Are you Homeless: __ Yes __ No Are you Disabled: __Yes __ No

**Other Information:**

Preferred Pharmacy (Name/Location): ________________________________________________________________________

Secondary Pharmacy (Name/Location): _______________________________________________________________________

**If your PCP is not Compassion Health Care, Inc., please complete the following:**

PCP Name: _______________________________________ Practice Name: ________________________________________

Practice Phone Number: ______-______-___________

**Please complete the following if patient is aged 18 or older:**

**Marital Status:**

- Married ☐
- Divorced ☐
- Partner ☐
- Single ☐
- Widowed ☐
- Legally Separated ☐

**Employment Status**

- Full Time ☐
- Part Time ☐
- Not Employed ☐
- Self Employed ☐
- Retired ☐
- Active Military ☐
- Reserved for National Assignment ☐

**Advanced Directives (Check all that apply)**

- VA Advanced Directive for Health Care ☐
- Do Not Resuscitate ☐
- Living Will ☐
- MOST Form ☐
- Active Medical Power of Attorney on File ☐

**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 me or my dependents 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 balance due that Compassion Health Care, Inc. is unable to collect from my insurance carrier, for any 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 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 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 the 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 any 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/medical provider 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.*

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

## Patient Medical History Information

(Revised 8/16/2023)

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<br>❑Shortness of breath while lying down<br>❑Palpitations | | ❑Chest pain during strenuous activities<br>❑Swelling of ankles | |
| ***Respiratory:*** | ❑Coughing | ❑Wheezing | ❑Shortness of Breath | ❑Snoring |
| ***Gastrointestinal:*** | ❑Nausea<br>❑Blood in Stool | ❑Vomiting<br>❑Abdominal Pain | ❑Diarrhea<br>❑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<br>❑Seizure Activity | ❑Tingling | ❑Paresthesia/Numbness | ❑Local weakness |
| ***Psychiatric:*** | ❑Anxiety | ❑Depression | ❑Moodiness | |
| ***Endocrine:*** | ❑Excessive Thirst | ❑Change in Weight | | |
| ***Hematologic/Lymphatic:*** | ❑Abnormal Bleeding | ❑Anemia | | |

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

## Disclosure of Protected Health Information

(Revised 8/16/2023)

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* *Phone*

____________________________________ ____________________ ____________________
*Name* *Relationship* *Phone*

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*

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

# Financial Policy (Private Insurance and Self-Pay Patients)

(Revised 8/11/2023)

Any healthcare insurance policy that you may have is a contract between you and your insurance company or employer. Compassion Health Care, Inc. (CHC) will assist you in obtaining payment from any healthcare insurance policy for medical services that you receive at any CHC location; however, you remain primarily responsible to pay for all medical services that you receive from us.

Patient Name: ______________________________________________ Date of Birth: ____/____/________

**Who is financially responsible for the patient?**

Name: ___________________________________ Relationship to Patient: ____________________________

**Is the patient currently covered by insurance?** ______ Yes ______ No

**Please remember to present the current insurance card(s) at every visit.*

Insurance Carrier: ____________________________ Second Insurance Carrier: ____________________________

| | |
|---|---|
| ________ Initial | **You are responsible for co-payments, coinsurance, and deductibles**, depending upon the insurance coverage. We require that co-payment be made at the time of service as well as deductibles if they have not been met. You also remain responsible for any balances due to co-payment, coinsurance, and deductibles. |
| ________ Initial | **Payment is due when services are provided.** At your office visit, if you are not able to pay the co-payment, we will be happy to reschedule your appointment when you are able to. |
| ________ Initial | Compassion Health Care, Inc. accepts MasterCard, Visa, American Express, and Discover, as well as cash, money orders, and checks for your convenience. There is a service charge for any returned checks. You will be charged $25.00 service charge along with the amount of the returned check within five (5) business days. |
| ________ Initial | In the event you receive a statement in the mail from us for payment, it is your responsibility to pay that amount promptly. After 60 days of nonpayment, you will receive a final payment request letter. You will then have 10 days to pay in full. If you cannot pay your bill, it is your responsibility to contact CHC's Billing Department to discuss a payment plan. The CHC Billing Department can be reached at (336) 694-9331, Option 4. |
| ________ Initial | By initialing here, you acknowledge that you have been made aware that CHC offers a sliding fee discount program to patients who qualify based on family size and income. |

I have read and understand the financial policy of Compassion Health Care, Inc. and agree to be bound by it. I understand that healthcare insurance does not cover all medical services and I understand my responsibilities with respect to healthcare insurance as explained above. I understand that I am ultimately responsible for payment for medical services provided to me or my dependent(s) by Compassion Health Care, Inc. I hereby grant Compassion Health Care, Inc. the right to bill and collect from my healthcare insurance plan for medical services provided to me or my dependent(s).

Signature: ____________________________________________________ Date: ____/____/________

Compassion Health Care, Inc. is a Federally Qualified Health Center. As such, we are required to report demographic and statistical data. This information requested below will help us better serve those who need assistance. Please be assured that your information is never reported on an individual basis and will only be included anonymously with our compiled data.

**Financial Information**

How many people live in the household? _____________

Total household income: __________________________

Is this Monthly | Annually (circle one)

If you choose not to disclose, please initial here: ______________

COMPASSION HEALTH CARE

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

# Sliding Fee Application

(Revised 8/16/2023)

**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 responsible 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 ___ / ___ / _____