



Patient Registration Form

(Revised 12/27/2023)

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 age 18 or older)

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

Race:

- Asian Indian
Chinese
Filipino
Japanese
Korean
Asian
Native Hawaiian
Other Pacific Islander
Guamanian or Chamorro
Samoan
Black/African American
American Indian/Alaska Native
White
Other Race:
Declined to Specify

Current Gender Identity (If age 18 or older)

- Male
Female
Transgender Male (Female to Male)
Transgender Female (Male to Female)
Other (Genderqueer, Non-Binary)
Choose not to disclose

Ethnicity:

- Chicano
Cuban
Hispanic or Latino
Mexican
Mexican American
Puerto Rican
Not Hispanic or Latino
Declined to Specify

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.*



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)

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes (Sugar) | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Other (Please Describe): _____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia | _____ |
| <input type="checkbox"/> Asthma/Emphysema | <input type="checkbox"/> Broken Bones | _____ |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Phlebitis | _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Skin Disease | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Gout | |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatic fever | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> German Measles | |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Chicken Pox | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Peptic Ulcer | |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Vaginal Infection | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sexually Transmitted Disease (STD) | |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> High Cholesterol | |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Blood Transfusion | |

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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Continue on next page...

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

- | | | | | |
|---|---------------------------------------|---------------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> Tonsils/Throat | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Ear | <input type="checkbox"/> Eye | <input type="checkbox"/> Stomach |
| <input type="checkbox"/> Gall bladder | <input type="checkbox"/> Appendix | <input type="checkbox"/> Colon | <input type="checkbox"/> Kidney | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Bone | <input type="checkbox"/> Prostate | <input type="checkbox"/> Circumcision | <input type="checkbox"/> Vasectomy | <input type="checkbox"/> Heart |
| <input type="checkbox"/> Lung | <input type="checkbox"/> Breast | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> C-Section | <input type="checkbox"/> Ovaries |
| <input type="checkbox"/> Tubal Ligation | <input type="checkbox"/> 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 Chest pain during strenuous activities
Shortness of breath while lying down Swelling of ankles
Palpitations
- Respiratory:** Coughing Wheezing Shortness of Breath Snoring
- Gastrointestinal:** Nausea Vomiting Diarrhea Constipation
Blood in Stool Abdominal Pain Heartburn
- 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 Tingling Paresthesia/Numbness Local weakness
Seizure Activity
- 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



Financial Policy (Private Insurance and Self-Pay Patients)
(Revised 2/12/2024)

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: _____

Phone: (____) _____ - _____

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: _____

Table with 2 columns: Initial and Text. Contains 5 rows of policy details regarding co-payments, payment due dates, accepted payment methods, nonpayment consequences, and sliding fee discounts.

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.

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		___ / ___ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2		___ / ___ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3		___ / ___ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
4		___ / ___ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
5		___ / ___ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
6		___ / ___ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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 ____ / ____ / _____