

**Patient Information**

Name of Patient

(Last)

(First)

(Middle)

Home Address

(Mailing)

(City/State/Zip)

Marital Status

Single

Married

Divorced

Widowed

Veteran Status

YES

NO

Home Telephone ( ) -

Work Phone ( ) -

Family Physician

(Name)

(City)

(Phone)

Age

Date of Birth

Social Security Number

Race

Household Income

Ethnicity

Number of Household Members

Employer

Phone ( ) -

Address

(Mailing)

(City/State/Zip)

Emergency Contact (Not living at same address as patient)

Phone

**Spouse / Guardian Information**

Name of Spouse / Guardian

(Last)

(First)

(Middle)

Address

(Mailing)

(City/State/Zip)

Age

Date of Birth

Social Security Number

Spouse / Guardian Employer

Home Telephone ( ) -

Cell Phone ( ) -

**Responsible Party Information**

Name of Responsible Party

(Last)

(First)

(Middle)

Address

(Mailing)

(City/State/Zip)

Age

Date of Birth

Social Security Number

Responsible Party Employer

Home Telephone ( ) -

Cell Phone ( ) -

**Notice of Additional Fees**

**I understand that there may be additional fees assessed by outside laboratory and/or radiological reading services. These fees will be billed separately and are due upon receipt.**

Signature

Date

Relationship

**Patient Responsibility for Charges**

**I understand that all charges incurred for my care are my responsibility. Community Health & Emergency Services, Inc. will submit my insurance claim as a courtesy, however, I understand that I am ultimately responsible for any balance left unpaid by my insurance.**

Signature \_\_\_\_\_

Date \_\_\_\_\_

# Community Health & Emergency Services, Inc.

Registration Form - Page 2

**Payment is expected at time of service unless other arrangements have been made in advance.**

**Please Give Receptionist a Photo ID (Drivers License) and ALL Insurance, Medicare and Public Aid Cards**

### Method of Paying Account

- |                                     |   |
|-------------------------------------|---|
| <input type="checkbox"/> Cash       | <input type="checkbox"/> General Assistance     |
| <input type="checkbox"/> Medicare   | <input type="checkbox"/> Insurance              |
| <input type="checkbox"/> Public Aid | <input type="checkbox"/> Pediatric Primary Care |

**You may be eligible for a discount for today's service based on your family size and income. Please ask the receptionist for details on our sliding fee program.**

Primary Insurance Carrier

(Insurance Company Name & Address)

Policy Number

Group Number

Insured Name

Secondary Insurance Carrier

(Insurance Company Name & Address)

Policy Number

Group Number

Insured Name

### Notice to General Assistance Patients

**Please be aware that General Assistance pays for primary care office visits and medically necessary laboratory tests only. Injections of any kind are not covered. General Assistance patients may apply for our sliding fee program for any non-covered services. You are responsible for payment of any services that are not covered by your General Assistance card.**

Signature

Date

Relationship

Do you have an advanced directive / living will?

YES NO

If you would like information on advanced directives, please inform the receptionist.

### Consent to and Authorization of Procedures of Care

**I consent to the administration of all routine medical and dental examinations and treatments, and all other related care to myself (or the minor patient) that may be ordered by physicians, dentists and/or any other providers of Community Health & Emergency Services, Inc. This consent shall remain in effect for two (2) years regardless of the number of visits, unless the undersigned gives written revocation of this consent.**

Signature

Date

Relationship

Witness

Title

### Consent for Purposes of Treatment, Payment and Healthcare Operations

All references to 'me' or 'my' refer to myself or the minor patient whom I am the guardian of.

I consent to the use or disclosure of my protected health information by Community Health & Emergency Services, Inc. (CHESI) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of CHESI. I understand that diagnosis or treatment of me by CHESI may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. CHESI is not required to agree to the restrictions that I may request. However, if CHESI agrees to a restriction that I request, the restriction is binding on CHESI and CHESI clinic providers.

I have the right to revoke this consent, in writing, at any time, except to the extent that CHESI has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by physicians, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review CHESI's Notice of Privacy Practices prior to signing this document. CHESI's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of health care operations of CHESI. The Notice of Privacy Practices for CHESI is also provided at our CHESI facility locations and on the CHESI website at [www.chesi.org](http://www.chesi.org). This Notice of Privacy Practices also describes my rights and CHESI's duties with respect to my protected health information.

CHESI reserves the right to change privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing CHESI's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature

Date

Relationship

Witness

Title