

Name of Patient \_\_\_\_\_  
(Last) (First) (Middle)

Home Address \_\_\_\_\_  
(Mailing) (City) (State) (Zip)

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Social Security Number \_\_\_\_\_

Marital Status: (Circle one) Single Married Divorced Widowed

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

How would you like to be contacted (circle one): Home Phone Work Phone Other Phone  
Student Status: (Circle one) Yes No If Yes: (Circle one) Full Part

Veteran Status: (Circle one) Yes No Race \_\_\_\_\_ Ethnicity \_\_\_\_\_

Number of Household Members \_\_\_\_\_ Household Income \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
(Mailing) (City) (State) (Zip)

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Name of Guardian \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
(Last) (First) (Middle)

Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
(Mailing) (City) (State) (Zip)  
Social Security Number \_\_\_\_\_

Guardian Employer \_\_\_\_\_

Primary Insurance Carrier \_\_\_\_\_ Card Holder Name \_\_\_\_\_  
(Insurance Company Name & Address)

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_ Insured Name \_\_\_\_\_

Secondary Insurance Carrier \_\_\_\_\_ Card Holder Name \_\_\_\_\_  
(Insurance Company Name & Address)

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_ Insured Name \_\_\_\_\_

Do you have an advanced directive / living will? YES \_\_\_ NO \_\_\_ If you would like information on advanced directives, please inform the receptionist.

**\*Notice of Additional Fees**

I understand that there may be additional fees assessed by outside laboratory and/or radiological reading services. You will receive a separate bill for these services, from the outside entity.

**\*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. If I fail to make a payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above account may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment.

**\*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

Registration Form Page 2

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.

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 I 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.

PAYMENT IS EXPECTED AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE

Method of Paying Account

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

\*Consent for Purposes of Treatment, Payment and Healthcare Operation

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 the health care operations of CHESI.

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. 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 visting CHESI's website, at http://www.chesi.org, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment

HIPAA INFORMATION: Please check all that apply.

(AREA) (PREFIX) (NUMBER)

(AREA) (PREFIX) (NUMBER)

HIPAA Info Community Health & Emergency Services, Inc. may:

Leave message at your home? YES NO Leave message at your place of work? YES NO

Leave message at school? YES NO Leave a message on a listed cell? YES NO

May we discuss your medical condition with any member of your household, family, relative or close personal friend?

YES NO If yes, whom

(RELATIONSHIP TO PATIENT)

(TELEPHONE)

Additional HIPAA comments:

PLEASE GIVE RECEPTIONIST A PHOTO ID (DRIVERS LICENSE) AND ALL INSURANCE, MEDICARE AND MEDICAID CARDS.

Signature Date Relationship

Witness Title