CommunityHealth
& EMERGENCY SERVICES

Patient Information:

Name of Patient:_____
(Last) (First) (Middle) (Suffix) (Maiden)

Social Security Number_____ Date of Birth:_____ Sex: ☐ M ☐ F

Home Address:_____
(Street) (City) (State) (Zip)

Preferred Language:_____

Check the Appropriate Response below

Preferred Contact Method:	☐ Home Phone	☐ Work Phone	☐ Cell Phone	
Marital Status:	☐ Single	☐ Married	☐ Divorced	☐ Widowed
Student Status:	☐ Yes	☐ No	☐ Full Time	☐ Part Time
Veteran Status:	☐ Yes	☐ No		
Smoker:	☐ Yes	☐ No		

Primary Medical Provider:_____ Primary Dental Provider:_____

Home Phone:_____ Day Phone:_____ Cell Phone:_____

Email Address:_____

Employer Name:_____ Employer Phone:_____

Employer Address:_____
(Street) (City) (State) (Zip)

UDS: (Check the appropriate response)

Homeless Status: ☐ Doubling Up ☐ Not homeless ☐ Shelter ☐ Street ☐ Transitional
Migrant Worker Status: ☐ Migrant ☐ Not a Farm Worker ☐ Seasonal
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White
☐ Decline to Specify ☐ Hispanic or Latino (All Races) ☐ Native American or Pacific Islander
Ethnicity: ☐ Decline to Specify ☐ Hispanic or Latino ☐ Not Hispanic or Latino

HIPAA INFORMATION: May CHESI discuss your medical condition with any member of your household, family, relative or close personal friend.

YES ☐ NO ☐ If yes, with whom:_____

Relationship to Patient:_____ Telephone Number:_____

Comments:_____

_____

Relationship Information:

Birth Mother's Name (if patient under 18):_____
(Last) (First) (Middle) (Maiden)

Name of Guardian/Spouse/Responsible Party:_____
(Last) (First) (Middle)

Social Security Number_____ Date of Birth:_____ Sex: ☐ M ☐ F

Home Address:_____
(Street) (City) (State) (Zip)

Home Phone:_____ Day Phone:_____ Cell Phone:_____

Employer Name:_____ Employer Phone:_____

Employer Address:_____
(Street) (City) (State) (Zip)

Number of Household Members:_____ Total Household Income:_____

Insurance Information:

Primary Insurance:_____

Policy Number:_____ Group Number:_____

Insured Name:_____
(Last) (First) (Middle)

Card Holder Name:_____
(Last) (First) (Middle)

Social Security Number_____ Date of Birth:_____ Sex: ☐ M ☐ F

Home Address:_____
(Street) (City) (State) (Zip)

Home Phone:_____ Day Phone:_____ Cell Phone:_____

Secondary Insurance:_____

Policy Number:_____ Group Number:_____

Insured Name:_____
(Last) (First) (Middle)

Card Holder Name:_____
(Last) (First) (Middle)

Social Security Number_____ Date of Birth:_____ Sex: ☐ M ☐ F

Home Address:_____
(Street) (City) (State) (Zip)

Home Phone:_____ Day Phone:_____ Cell Phone:_____

Emergency Contact Information:

Name of Emergency Contact:_____
(Last) (First) (Middle)

Social Security Number_____ Date of Birth:_____ Sex: ☐ M ☐ F

Home Address:_____
(Street) (City) (State) (Zip)

Home Phone:_____ Day Phone:_____ Cell Phone:_____

Please read and initial:

***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. **Initials:**_____

***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 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. **Initials:**_____

***PAYMENT IS EXPECTED AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENT HAVE BEEN MADE IN ADVANCE.**
Methods of payment include private insurance, Medicare, and Medicaid. You may also be eligible for a discount for today's services based on your family size and income. Please ask the receptionist for details on our sliding fee program. **Initials:**_____

***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. **Initials:**_____

***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 and 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. **Initials:**_____

***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 of disclosure of my protected health information by Community Health and 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. **Initials:**_____

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 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 the 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 visiting CHESI's website at 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. **Initials:** _____

PLEASE PRESENT COMPLETED FORMS TO A RECEPTIONIST ALONG WITH A PHOTO ID AND ALL INSURANCE CARDS.

SIGNATURES:

_____ _____

(Patient or Guardian Signature) **(Date)**

_____ _____

(Witness Signature) **(Date)**