COMMUNITY HEALTH CENTERS

PATIENT REGISTRATION FORM

MRN:	SSN:
Name:	Date of Birth:
Address: City:	State: Zip:
Home Phone#:	Cell Phone#:
Work Phone#:	Email:
Can confidential messages be left on your home answering machine or cell phone* voicemail? [ ] Yes [ ] No ***Please note a cell phone is not a secure and private line**	
Sex:	Relationship Status: [ ] Single [ ] In Relationship [ ] Married [ ] Separated [ ] Divorced [ ] Widowed
Gender Identity: [ ] Male [ ] Female [ ] Transgender Male/Female-to-Male [ ] Transgender Female/Male-to-Female [ ] Something else [ ] Choose not to disclose	
Primary Emergency Contact: Emergency Phone#: Secondary Emergency Contact: Emergency Phone#:	Relationship: Relationship:
IF PATIENT IS UNDER 18 / HAS GUARDIAN Responsible Party Name: Relationship to Patient:	Phone#:
Pharmacy: Special Hearing Needs:	Pharmacy Location: Special Vision Needs:
Race (*check all that apply*): [ ] American Indian or Alaskan Native [ ] Native Hawaiian [ ] Other Pacific Islander [ ] Asian [ ] Black/African American [ ] White [ ] Something else [ ] Choose not to disclose	
Preferred Language: [ ] English [ ] Spanish [ ] Sign Language [ ] Other (*please describe*)	
Are you Hispanic or Latina/o? [ ] Yes [ ] No [ ] Choose not to disclose	
Sexual Orientation: [ ] Straight [ ] Lesbian or Gay [ ] Bisexual [ ] Something else [ ] Don't Know [ ] Choose not to disclose	
Are you an agricultural worker or the dependent of an agricultural worker? [ ] Yes [ ] No	
Are you a veteran NOT currently serving in the military? [ ] Yes [ ] No	
Are you living in Public Housing? [ ] Yes [ ] No	
Are you currently homeless (doubled up, living in transitional housing, living in a shelter, living on the street)? [ ] Yes [ ] No If YES, what is your current status? (Check all that apply) [ ] Doubled up [ ] Transitional housing [ ] In a shelter [ ] On the street [ ] Other (*please describe*)	

ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

Thank you for choosing Appalachian Mountain Community Health Centers (AMCHC) as your healthcare provider. This is a summary of our patient financial policy.

Appalachian Mountain Community Health Centers (AMCHC) will:

- Accept cash, check, debit or credit card payments.
- File insurance claims for services provided.
- Collect fees or insurance co-payments at the time of service. **Some lab work performed at our practice and all lab work performed at an outside lab will NOT be included in the fee or co-pay required at the time of service.**
- Offer a sliding scale fee discount program and apply a schedule of discounts.
- Take steps to collect fees due from patients, including statements, payment plans and collections.

As a patient of AMCHC, you are expected to:

- Make any required payments at the time of service.
- Provide AMCHC current and correct insurance information.
- Provide information needed to determine eligibility for the sliding fee discount program.
- Update insurance, income, and other information when there are changes.
- Work with AMCHC to set up and follow payment plans.

If you need more information, please ask to speak to an AMCHC staff member.

I have read and understand the above: ______________________________ **Date:**______________

Patient, Parent or Guardian Signature

Note: Failure to sign does not relieve you of the above expectations

INCOME INFORMATION

AMCHC asks you to share information about your income and family size in order to make sure we are serving the whole community, including low-income patients. AMCHC does not share your individual financial information with any other organization and this information will not be used to withhold or deny services.

What is your annual income? ____________________ How many people live in your household? ________________

VERBAL COMMUNICATION CONSENT

Appalachian Mountain Community Health Centers (AMCHC) is authorized to discuss medical and financial information concerning the care and services provided to me with the following individuals:

Name:______________________________ Relationship:____________________ Phone#:______________

Name:______________________________ Relationship:____________________ Phone#:______________

Date:________________

CONSENT FOR TREATMENT

I hereby consent to medical treatment/s, diagnostic procedure(s), and diagnostic lab(s). I acknowledge that any lab work performed at our practice is also a part of Mission Hospital's medical records. I understand I have the right to ask questions about my treatment or procedures and I agree to notify my provider of my concerns.

Patient, parent or guardian signature ______________________________ **Date** ________________

NOTICE OF PRIVACY ACKNOWLEDGMENT

I have been given the opportunity to read AMCHC's Notice of Privacy Practices, and my questions concerning the Notice have been answered. I understand if I choose not to sign this acknowledgment AMCHC will continue to provide services to me and will use and disclose my Protected Health Information (PHI) for treatment, payment, and healthcare operations when necessary.

Patient, parent or guardian signature ______________________________ **Date**________________

Patient Financial and Insurance Policy

Thank you for choosing Appalachian Mountain Community Health Centers (AMCHC) as your healthcare provider. We are committed to developing and maintaining supportive relationships with you and your family and we want your patient experience to be a good one. Payment for the services you receive at AMCHC is an important part of sustaining that relationship. Our financial policy helps to make sure that we can provide quality care to all of our patients.

1. Payment owed for services received at AMCHC is due at the time of service. If a patient fails to make a payment at the time of service, AMCHC will bill the patient and expect timely payment to be made.

2. AMCHC will offer a sliding fee discount program and apply a discount to the amount owed for services for eligible patients. Eligibility for discounts is based on income and family size. All AMCHC patients may be assessed for eligibility for the sliding fee discount program.

3. AMCHC has staff available to help patients understand the sliding fee discount program, review eligibility for discounts, and assist in setting up a payment plan for amounts owed to AMCHC.

Insurance Policy Notice

As a healthcare provider, AMCHC participates with Medicaid, Medicare, and many commercial insurance companies. If you have insurance, AMCHC will file claims with your insurance company for the services you receive. It is important that your insurance information is complete and current, and that you provide any updates to AMCHC staff. Patients may be held financially responsible for all charges, whether covered and/or paid by insurance.

Eligibility Form

Patient Name: ______________________________ **MRN:** ____________

AMCHC defines a family member as anyone within the residence to whom the patient provides or from whom the patient receives financial support including, but not limited to: self, spouse or partner and dependent children. Please list all members of your family that you wish to include in your household size. AMCHC uses monthly gross income to project annual gross income. Annual gross income is used to determine eligibility for discounted services. The following sources of money income should be included: earnings, unemployment compensation, workers' compensation, Social Security, Social Security Disability Income (SSDI), Supplemental Security Income (SSI), public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household and other miscellaneous sources.

Approved proof of income sources include, but are not limited to: most recent federal tax return, paycheck stubs, bank statement, letter from an employer, statement of income determination from federal, state, or local government (e.g. Social Security, SSI, SSDI, public assistance, veterans' payments), the *No Proof of Income Verification Form* and the *Homelessness Verification Form* and supporting documentation.

Family Member (Name)	Date of Birth	Relationship to Applicant	Monthly Income
		Self	$
			$
			$
			$
			$
			$
			$
			$
		Total Household Income	$

I certify that the information given on this form and the provided income documentation is complete, true and correct. If I do not qualify for financial assistance, I agree to pay the outstanding balance in full. I agree and understand that any remaining balance not paid through financial assistance will be my responsibility and paid in full. I understand that financial assistance may not apply to all of the services provided at AMCHC. I understand that financial assistance may expire on or before the date indicated below and I will be required to reapply. If there is a change in income, I will submit a new *Eligibility Form* and income documentation.

☐ I choose not to provide information and/or documentation of my household income and understand this will result in my ineligibility for discounts through the sliding fee discount program.

SIGNATURE: ______________________________ DATE: ____________

EMPLOYEE VERIFYING: ______________________________

You qualified for the following discount (*circle one*):

LEVEL 4 **LEVEL 3** **LEVEL 2** **LEVEL 1** **LEVEL 0 (*point-of-care incentive only*)**

☐ Sliding fee discount program is not applicable based on information provided.

FINANCIAL ASSISTANCE APPROVED UNTIL: ______________________________

Medical, Family & Social History

Name: ______________________________ **DOB:** ____________________

Reason for Visit:

____

____

____

Allergies:

____

____

Reaction to Allergen:

____

____

____

Medications: List all medications (e.g. prescribed, over-the-counter, vitamins, herbs, birth control) even if you do not take them every day.

Name of Medication	Dose/No. of tabs	Frequency

Medical History:

- ☐ Hypertension
- ☐ Chronic Pain
- ☐ Insomnia
- ☐ Bowel Issues
- ☐ Edema
- ☐ Traumatic Brain Injury
- ☐ Cancer
- ☐ GERD
- ☐ Diabetes (Type I or II)
- ☐ Heart Disease
- ☐ Asthma
- ☐ Hyperlipidemia
- ☐ COPD
- ☐ Bipolar
- ☐ Depression
- ☐ Anxiety
- ☐ PTSD
- ☐ ADHD
- ☐ Schizophrenia
- ☐ Borderline Personality Disorder
- ☐ Schizoaffective Disorder
- ☐ Alcohol Dependency
- ☐ Drug Dependency
- ☐ Tobacco Dependence

Other Diagnoses Not Mentioned Above:

____

Next ⇒

Immunizations:

Tetanus (TDaP) ☐ Yes ☐ No Date:______________________
Pneumonia ☐ Yes ☐ No Date:______________________
Hepatitis A ☐ Yes ☐ No Date:______________________
Hepatitis B ☐ Yes ☐ No Date:______________________
Flu Shot ☐ Yes ☐ No Date:______________________

Have you had testing, and when?

HIV ☐ Yes ☐ No Date:______________________
Hepatitis C ☐ Yes ☐ No Date:______________________

Surgical History:

Type of Surgery	Date (month/year)

Any Emergency Department visits in the past 12 months?

☐ Yes ☐ No If yes, how many visits?

____

Hospitalizations (in the past 12 months):

Reason for Stay	Location (Hospital)	Date (Month/Year)

Family History:

☐ Diabetes Family Member:______________________
☐ Hypertension (high blood pressure) Family Member:______________________
☐ Heart Disease Family Member:______________________
☐ Mental Illness Family Member:______________________
☐ Cancer Family Member:______________________
☐
Other:______________________

Next ⇒

Social History:

Do you smoke currently? ☐ Yes ☐ No

If no, are you a former smoker? ☐ Yes ☐ No Start Date:_______Quit Date:______

If yes, how often do you smoke? ____

How many cigarettes a day? ____

How soon after you wake up do you have your first cigarette?_______________

Are you interested in quitting? ☐ Yes ☐ No

Any tobacco use, other than smoking? ☐ Yes ☐ No

Do you smoke marijuana? ☐ Yes ☐ No

Do you use any other drugs (other than tobacco) recreationally? ☐ Yes ☐ No

Have you had an alcoholic beverage in the past 12 months? ☐ Yes ☐ No

If yes, how often in the past 12 months? ____

How many alcoholic beverages do you consume on a typical day? ____________

How often have you had six (6) or more alcoholic beverages on one occasion in the past 12 months? ____

Do you consume caffeine? ☐ Yes ☐ No

If yes, how many cups/bottles/cans a day? ______________________________________

Do you exercise? ☐ Yes ☐ No

If yes, how often?____

Type of exercise?____

Mental Health:

During the past month, have you often been bothered by:

Little interest or pleasure in doing things? ☐ Yes ☐ No

Feeling down, depressed or hopeless? ☐ Yes ☐ No

Do you feel safe in your environment? ☐ Yes ☐ No

If no, please describe: ____

Do you have any other concerns about health or safety in your environment (e.g. experiencing homelessness, lack of food or utilities, etc.)? ☐ Yes ☐ No

If yes, please describe:____

Next ⇒

Sexual History:

Have you been sexually active in the past 12 months? ☐ Yes ☐ No

If yes, have you had sex with men, women, or both?______________________________

How many sexual partners have you had in the past 12 months?_____________

How often have you used protection in the past 12 months?

☐ Never

☐ Some of the time

☐ Half of the time

☐ Most of the time

☐ All of the time

Type of protection used? ____

If no, have you ever been sexually active? ☐ Yes ☐ No

Do you have sex with men, women, or both?_____________________________

How many sexual partners have you had?________________________________

Do you have any concerns about keeping yourself sexually healthy and safe? ☐ Yes ☐ No

If yes, please describe:____

For Female* Patients:

Total number of pregnancies to-date: ____

Total number of living children: ____

Are you pregnant currently? ☐ Yes ☐ No

Are you breastfeeding currently? ☐ Yes ☐ No

Date of your last menstrual period:____

Have you ever had a Pap smear? ☐ Yes ☐ No

If yes, date:____________________ Results: ☐ Normal ☐ Abnormal

Have you ever had a mammogram? ☐ Yes ☐ No

If yes, date:____________________ Results: ☐ Normal ☐ Abnormal

For Male* Patients:

Have you ever had a prostate screening/test? ☐ Yes ☐ No

If yes, date:____________________ Results: ☐ Normal ☐ Abnormal

**For the purposes of these questions, "female" and "male" refer to sex assigned at birth, rather than gender identity.*

Health Screening Questionnaire – New patient

Patient Name: ______________________________ **Date of Birth:** _______________

Date of Visit: ______________

All of our patients are asked to complete this questionnaire because drug use, alcohol use, mood and stressful experiences can affect your current health as well as medications you may take.

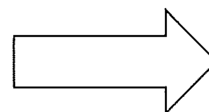
Please help us provide you with the best medical care by answering the questions below.

A. Depression *(PHQ9)*

Over the last two weeks, how often have you been bothered by the following problems? (use ✓ to indicate your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things?	0	1	2	3
Feeling down, depressed, or hopeless?	0	1	2	3
Trouble falling or staying asleep, or sleeping too much?	0	1	2	3
Feeling tired or having little energy?	0	1	2	3
Poor appetite or overeating?	0	1	2	3
Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television?	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way?	0	1	2	3
	_____	+ _____	+ _____	+ _____

Total Score = _____

PLEASE CONTINUE TO OTHER SIDE



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COMMUNITY HEALTH CENTERS

B. Are you currently in recovery for alcohol or substance use? ☐ Yes ☐ No

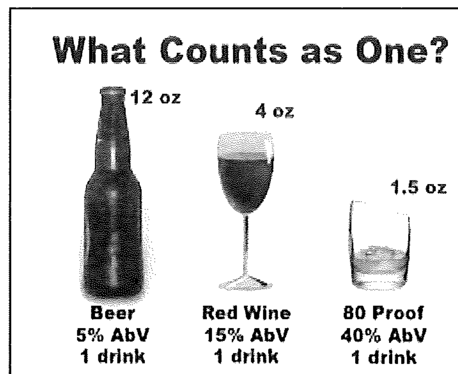
C. How many times in the past year have you had:

(Men) 5 or more drinks in one day

☐ none ☐ 1 or more

(Women) 4 or more drinks in one day

☐ none ☐ 1 or more



D. How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons? ☐ none ☐ 1 or more

Recreational drugs include: *cannabis (marijuana, pot), cocaine, stimulants (Ritalin, Concerta, Adderall), methamphetamine (speed, crystal), inhalants (paint thinner, aerosol, glue), sedatives (Valium, Xanax, Klonopin), hallucinogens (LSD, mushrooms, ecstasy), street opioids (heroin, fentanyl).*

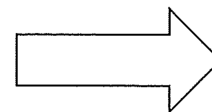
Prescription opioids include: *fentanyl, oxycodone (OxyContin), Percocet, hydrocodone (Vicodin),methadone, buprenorphine.*

G. Anxiety *(GAD 7)*

Over the last two weeks, how often have you been bothered by the following problems? **(use ✓ to indicate your answer)**	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3
	_____ +	_____ +	_____ +	_____

Total Score = _____

PLEASE CONTINUE TO OTHER SIDE



F. Adverse Childhood Events *(ACE)*

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often**... Swear at you, insult you, put you down, or humiliate you? **or** Act in a way that made you afraid that you might be physically hurt?
   No____ If Yes, enter 1___
2. Did a parent or other adult in the household **often**... Push, grab, slap, or throw something at you? **or** Ever hit you so hard that you had marks or were injured?
   No____ If Yes, enter 1___
3. Did an adult or person at least 5 years older than you **ever**... Touch or fondle you or have you touch their body in a sexual way? **or** Attempt or actually have oral, anal, or vaginal intercourse with you?
   No____ If Yes, enter 1___
4. Did you **often** or feel that ... No one in your family loved you or thought you were important or special? **or** Your family didn't look out for each other, feel close to each other, or support each other?
   No____ If Yes, enter 1___
5. Did you **often** feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **or** Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   No____ If Yes, enter 1___
6. Were your parents **ever** separated or divorced?
   No____ If Yes, enter 1___
7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her? or **Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard? **or Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?
   No____ If Yes, enter 1___
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   No____ If Yes, enter 1___
9. Was a household member depressed or mentally ill, or did a household member attempt suicide? No____ If Yes, enter 1___
10. Did a household member go to prison?
    No____ If Yes, enter 1___

Now add up your "Yes" answers: ______ This is your ACE Score

NOTE: The role of adverse childhood experiences (ACEs) in predicting later adverse adult health outcomes is widely recognized in the healthcare community. Gathering this information has the potential to identify unaddressed key social issues that can influence current health risks, morbidity, and early mortality.

PLEASE CONTINUE TO OTHER SIDE

E. Intimate partner violence:

Have you been hit, kicked, punched or otherwise hurt by someone in the past year?	☐ Yes ☐ No
Do you feel safe in your current relationship?	☐ Yes ☐ No
Is there a partner from a previous relationship or anyone else who is making you feel unsafe now?	☐ Yes ☐ No

THANK YOU FOR COMPLETING THIS HEALTH QUESTIONNAIRE.

PLEASE CONTINUE TO OTHER SIDE