CommuniCare
HEALTH CENTERS

PATIENT REGISTRATION

Patient Information

Last Name	First Name	Middle Name
Social Security Number	Birth Date *(mm/dd/yyyy)*	Suffix
Mailing Address		Apt/Suite No.

City	State	Zip	County

Mobile Phone	Phone #2 ☐ Home ☐ Work	Email Address

May we text you with appointment information/reminders?	☐ Yes ☐ No	May we email you with appointment information/reminders?	☐ Yes ☐ No

Primary Legal Guardian (Any Patient under the age of 18 must have a legal guardian)

I am: ☐ Patient (if 18 years or older) ☐ Custodial Parent ☐ Guardian

Last Name	First Name	Middle Initial	Parent/Guardian Date of Birth *(mm/dd/yyyy)*	Suffix

Home Address	City	State	Zip

Email Address	Mobile Phone	Phone #2 ☐ Home ☐ Work

Secondary Legal Guardian (Any Patient under the age of 18 must have a legal guardian)

I am: ☐ Patient (if 18 years or older) ☐ Custodial Parent ☐ Guardian

Last Name	First Name	Middle Initial	Parent/Guardian Date of Birth *(mm/dd/yyyy)*	Suffix

Home Address	City	State	Zip

Email Address	Mobile Phone	Phone #2 ☐ Home ☐ Work

Others authorized to bring child in for care

Relation to Patient:

Last Name	First Name	Middle Initial	Suffix

Home Address	City	State	Zip

Email Address	Mobile Phone	Phone #2 ☐ Home ☐ Work

Emergency Contacts
Who would we call in case you are incapable or need assistance while you are here or if we had important information about your health care and could not reach you?

Name	Relation to Patient	Phone Number
Name	Relation to Patient	Phone Number

To help us better understand our patient population and factors that can impact your health, please answer the following: (***All your responses are kept confidential***)

Patient's Race
☐ Choose not to disclose ☐ Multi-Racial
☐ White ☐ Native Hawaiian
☐ Black / African American ☐ Other Pacific Islander
☐ Native American / Alaskan ☐ Asian

Patient's Primary Language **if not English:**

Military Service (refers to patient)
Are you a veteran? ☐ Yes ☐ No

Do you need Interpretive Services? ☐ Yes ☐ No

Ethnicity / Ethnic Origin
☐ Hispanic ☐ Non-Hispanic ☐ Choose not to disclose

Family Household Size __________ Household Income __________________ ☐ Choose not to disclose

Patient's Sexual Orientation
☐ Choose not to disclose ☐ Bisexual
☐ Straight (not lesbian or gay) ☐ Don't know
☐ Lesbian or Gay ☐ Something else

Patient's Gender Identity
☐ Choose not to disclose ☐ Other
☐ Male ☐ Transgender Female/Male-to -Female
☐ Female ☐ Transgender Male/Female-to-Male

Agriculture Employment: Have you now, or in the past worked as an agricultural worker?
☐ Yes. ☐ No ☐ Choose not to disclose

Housing Situation (last 12 months) : ____
☐ Choose not to disclose. *(house, with relative/friend, shelter, homeless, etc.)*

Insurance Information	Secondary Insurance Information
☐ I have Medical Insurance ☐ I do not have Medical Insurance ☐ I have Dental Insurance (see information below)	☐ **I would like to apply for the Discount Program**
Insurance Company Name:	Insurance Company Name:
Policy Holder's Name:	Policy Holder's Name:

Policy Number:	Policy Number:
Billing Address for Insurance:	Billing Address for Insurance:
Policy Holder's Social Security Number:	Policy Holder's Social Security Number:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Employer:	Policy Holder's Employer:

RELEASE OF INFORMATION/ FINANCIAL RESPONSIBILITY

I hereby authorize CommuniCare Health Centers (CCHC) to release any medical or other information needed to process all insurance claims. I authorize payment of insurance benefit directly to CCHC. I agree that I am responsible for payments for services rendered, deductibles and coinsurance. I am aware that failure to pay may result in termination of the patient/clinic relationship. A photocopy of this authorization shall be considered as valid as the original. This authorization will remain in effect until revoked by me in writing.

Health Information Exchange (H.I.E)

CommuniCare Health Centers participates in health information exchanges. This allows for your medical information to be securely shared with hospitals and other health organizations. This sharing of information allows for safer and more efficient quality of care when you visit health care organizations outside of Communicare Heath Centers. You have the options to not benefit from participating in the health information exchanges by opting out.

Please select one: ☐ Opt – out

Attention Medicaid / Medicare Patients

Medicare only covers Influenza, Pneumococcal, and Hepatitis B vaccines. If you have Medicare coverage, you must pay in full for any other vaccines you choose to receive in our center. We do not bill insurance for Behavioral Health services, except when Medicare or Medicaid is the PRIMARY payer. If you have any other insurance you will be accepted as a PRIVATE PAY patient for Behavioral Health, even if Medicaid is your secondary insurance.

Credit Card Information & Authorization

To enhance the convenience of your services, CommuniCare Health Centers can charge the credit card recorded above for rendered services by providing your authorization below:

I, ___________________________, authorize CommuniCare Health Centers to charge my credit card using the information above. I understand that my card information will be saved on file to be used for future transactions at CommuniCare Health Centers.

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other:		
Cardholder Name (As shown on card):		
Card Number:		
Card Expiration Date (MM/YY):	CVV:	Billing ZIP code:

Consent for Treatment

To be completed by the patient or the patient's legally authorized representative / parent:

CommuniCare Health Centers (CCHC) provides services regardless of race, residence, religion, income, sex, age, national origin, color, sexual orientation, gender identity, or contraceptive preference. I consent to medical treatment, dental treatment, electronic prescription history and diagnostic evaluation for myself or for the patient for whom I am the parent or legally authorized representative. Clinical and Dental procedures may include the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

In the event that a staff member has a serious exposure to my blood or bodily fluids. I consent to the anonymous testing of any blood samples that I have already provided for evidence of a blood-borne virus infection. I also acknowledge that test for certain communicable disease may be reportable to public health agencies as required by law. I understand that CommuniCare Health Centers will share patient health information according to federal and state law for treatment, payment, and operations.

I understand that I will have the opportunity to discuss with my CommuniCare provider the nature and purpose of recommended treatment or procedure(s), as well as alternative methods. I understand this consent is valid until revoked in writing, which I may do at any time.

Signature of Authorization

Signature of Patient or Guardian if patient is a minor: ____

Relationship to Patient:______________________________ Date: ____________________

CommuniCare HEALTH CENTERS

PATIENT AND CENTER RIGHTS AND RESPONSIBILITES

Welcome to CommuniCare Health Centers! As a patient of CommuniCare we want to ensure everyone mutually understands the expectations of the Center and you, as the patient, understand what we will do. We want to provide the best experience for you and your family. If you have questions regarding these rights and responsibilities, please ask.

A. **Human Rights**

You have a right to be treated with respect regardless of race, color, marital status, religion, sex, national origin, ancestry, physical or mental handicap or disability, age (over 40), or other grounds not permitted by applicable federal, state, and local laws or regulations.

B. Payment For Services:

1. You are responsible for giving us accurate information about your present financial status and any changes in your financial status. If your income is at or below 200% of the Federal Poverty Income Guidelines, you are eligible to apply for a discounted fee.
2. You have a right to receive an explanation of the Center's bill. You must pay all agreed fees in full for health services as provided by our facility. If you are unable to pay the fees; payment arrangements can be made at the discretion of the Center based upon medical necessity.
3. Federal law prohibits us from denying you primary health care services, which are medically necessary, solely because you cannot pay for these health services at the time of your medical visit. If in the event you do not make an attempt to comply with your financial responsibility, we have the right to discontinue our services to you. You will still be responsible for any outstanding balances on your account.

C. Privacy:

You have a right to have your interviews, examinations and treatment in privacy. Your medical records are also private. Only legally authorized persons may see your records, unless you request in writing for us to show them to, or copy them for, someone else. A complete discussion of your privacy rights will be given to you along with this document and is named "Notice of Privacy Practices". The Notice of Privacy Practices sets forth the way in which your medical records may be used or disclosed by the Center and the rights granted to you under the Health Insurance Portability and Accountability Act (HIPAA).

D. Health Care:

1. You are responsible for providing us complete and current information about your health or illness, so that we can give you proper health care. You have a right, and are encouraged, to participate in decisions about your treatment.
2. You have a right to information and explanation in the language you normally speak and in words you understand. You have a right to information about your health or illness, treatment plan, including the nature of your treatment; its expected benefits; its inherent risks and hazards (and the consequences of refusing treatment); the reasonable alternatives, if any (and the risks and benefits); and expected outcome, if known. This information is called obtaining your informed consent.
3. You have the right to receive information regarding "Advance Directives." If you do not wish to receive this information, or if it is not medically advisable to share that information with you, we will provide it to your legally authorized representative.
4. You are responsible for appropriate use of our services, which includes following staff's instructions, and making and keeping scheduled appointments. We may not be able to see you unless you have an appointment.
5. If you are an adult, you have the right to refuse treatment to the extent permitted by applicable laws and regulations. In this regard, you have the right to be informed of the risks, hazards, and consequences of your refusing such treatment or procedures. You are responsible for the outcome of refusing treatment.
6. You have a right to clinical care and treatment that is reasonable for your condition and within our capability; however, the Center is not an emergency care facility. You have a right to transfer care or be referred to another facility for services that we cannot provide. We do not pay for services that you get outside the Center.

E. **Center Rules:**

1. You have a right to receive information on how to appropriately use the Center and its services. You are responsible for using the Center and its program sites in an appropriate manner. If you have questions about using Center services, please ask.
2. You are responsible for the supervision of children you bring to the Center. You are responsible for their safety and the protection of other clients and our property.
3. You have a responsibility to keep your scheduled appointments. Missed appointments cause delay in treating other patients. If you cannot attend your appointment, please contact the clinic one business day prior to your appointment time to cancel.
4. Please allow three business days to refill your prescription. Please contact the pharmacy directly to refill prescriptions. Please do not wait until you are totally out of your medications to request refills.
5. We are not responsible for patient's and/or visitor's personal items within the clinic premises (facilities or parking lots). The clinic will not be held responsible for misplaced, stolen, or lost personal items.

F. **Complaints:**

1. If you are not satisfied with our services, please email your complaint to patientinquiry@communicaresa.org.
2. The Center will not punish, discriminate, or retaliate against you for filing a valid complaint; and will continue to provide you services.

G. **Termination:**

Reasons for which we may terminate your relationship with the Center include but are not limited to: (A) Failure to obey rules, (B) Persistent failure to keep scheduled appointments, (C) Intentional failure to report accurate information concerning your health, (D) Intentional failure to follow your health care plan, (E) manipulation of medication prescription, (F) Intentional failure to accurately report your financial status, (H) Non-compliance with payment plan. If we decide that we must stop treating you as a patient, you have a right to advance notice that explains the reason for the decision, and you will be given thirty (30) days to find other health services. You have a right to receive a copy of the Center's termination policy.

The Center **maintains ZERO TOLERANCE of abuse, harassment, or violence** of any kind. A person who causes or threatens to cause abuse, harassment or violence of any kind is subject to **immediate** termination as a patient of the Center and removal from the Center premises.

H. **Appeals**

- If the Center has given you a notice of termination, you have the right to appeal the decision.
- There is no appeal process for an immediate termination relating to abuse, harassment, or violence.

Missed Appointment Agreement

Medical, Dental, Women's Health, Behavioral Health, or Specialty Care patients who fail to keep or reschedule appointments in accordance with CommuniCare guidelines three times in a 12-month period will have all existing appointments canceled. You will only be seen on a walk-in or same-day basis as scheduling allows. Patients seen on a walk-in or same-day basis will be seen by any available provider.
Missed appointment is defined as:

- Failure to cancel or reschedule an appointment at least one business day prior to scheduled appointment time (cancelation and rescheduling must be done during clinic hours), or
- Failure to keep a scheduled appointment

Acknowledgment of Review of Notice Privacy Rights, Patient Rights & Responsibilities

I have reviewed the CommuniCare Health Centers Notice of **Patient Rights & Responsibilities**, which outlines my rights as a patient of CommuniCare Health Centers and defines my expected responsibilities as a CCHC patient. I understand that I am entitled to receive a copy of any or all of these documents.

Signature of Agreement

Signature of Patient or Guardian if patient is a minor: ____

Relationship to Patient: ____ Date: ____________________

NOTICE OF CLIENT PRIVACY RIGHTS

Clients are provided a copy of this Notice of Client Privacy Rights in Spanish and English at the time they sign the Center Patient and Center Rights and Responsibilities and upon request.

To our Clients:

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This notice applies to all of the records of your care generated by this Center, whether made by the Center or an associated provider. Our policies on protecting your health information extend to all professional authorized persons who have a need to know to provide care to you. The policies apply to all areas of the Center including all Center staff, the front desk, billing and administration. It also applies to any entity or individual with whom we contract services, such as referral providers.

Your Protected Health Information

As our patient, we create paper and electronic medical records and documents concerning you and your health, as well as the care and services we provide to you. We need this record to provide continuity of care and to comply with certain legal requirements. We are required by law to:

- make sure that your protected health information is kept private,
- provide you with this Notice of Client Privacy Rights, and
- make sure the law and your legal rights are in effect.

HOW WE MAY USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION

Treatment. We use information previously compiled about you to provide you with current or future health care treatment or services. Therefore, we may, and most likely will, disclose your information to doctors, nurses and other health care personnel who are involved in your care.
Payment. We may use and disclose medical information about you concerning services and procedures so they may be billed and collected from you, your insurance company or third party reimbursement entity such as Workers Compensation.
Operational Uses. We may use and disclose medical information about you in order to operate the Center efficiently and make sure our patients receive quality of care.
Appointment and Patient Recall Reminders. We may use and disclose your health information to contact you to remind you regarding appointments or for medical care that you are to receive.
External Entities. In an emergency, we may disclose information about you to an entity assisting in disaster relief so that your family can be notified about your condition, status and location.
Research. We may participate in research concerning the use of certain treatment protocols that have proper governmental and Center approval. In that case, we would secure your informed consent that will identify all aspects of your involvement, risks and benefits and possible disclosures.
Required by Law. We will disclose medical information about you when required to do so by federal, state or local law.
To Avert a Serious Threat to Health or Safety. We may use and disclose your health information to persons who need to know when necessary to prevent a serious threat to either your health or the health and safety of others.
Organ and Tissue Donation. If you are an organ donor, we may disclose medical information to organizations that handle organ procurement and transplantation.
Public Health Issues and Risks. We may report your health information as required by law or by your authorization concerning certain health conditions to prevent or control disease, injury or disability, births and deaths, child or elder abuse or neglect, reactions to medications or products, recalls of products, and notice of exposure to a condition.
Victims of Abuse, Neglect or Domestic Violence. We may disclose your health information to law enforcement, social services, or other government agencies authorized to receive the report if we have reason to believe that you are a victim of abuse, neglect, or domestic violence.
Investigations and Government Activities. We may disclose your health information to a local, state or federal agency for oversight activities authorized by law that may concern inspections, licensure, illegal conduct, or compliance with other laws and regulations including civil rights laws.
Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose your health information in response to a subpoena, court subpoena or court order, discovery request or other lawful process by someone else involved in the dispute.
Law Enforcement. We may release your health information to law enforcement officials in response to a court order, subpoena, warrant, summons or similar process, to identify or locate a suspect witness or missing person, concerning a victim of a crime, about a death we believe may involve criminal actions, criminal conduct in progress, crimes on Center premises, or emergency situations to report a crime or details of a crime.
Coroners, Medical Examiners and Funeral Directors. We may release your health information to a coroner or medical examiner or funeral directors as necessary for them to carry out their duties.
Military and National Security. If you currently serve in the military or are a veteran, we may disclose your health information to the military upon proper request. We may also disclose your information to federal officials conducting national security and intelligence activities.
Workers' Compensation. We may disclose your information if required by workers' compensation laws and other similar laws and regulations.

YOUR PRIVACY RIGHTS

You have the right to:

Inspect and copy your health information. You may ask to review and get a copy of health information about you that the Center keeps for as long as the Center has it. If you request to review your health information, the Center will determine whether to allow you to review some or all of the health information you asked for. The Center may charge a fee for any copies that you ask for. Please make this request in writing to the Center's Health Information Manager.

Amend your health information, if you feel it is wrong or not complete. You may request that we amend the health information the Center keeps. If the Center accepts your request to amend your health information, the change will become a permanent document in your health care record. Please make this request in writing to the Center's Health Information Manager.

Request a limit to the health information we disclose. You may ask the Center not to use or disclose your health information. Your request must describe the specific limits you are requesting. The Center may deny your request. Please make this request in writing to the Center's Health Information Manager. Request a list of disclosures we have made of your health information. You can request a list of disclosures of your health information that the Center has made. This list will not include routine disclosures of your health information for the treatment, payment, or business operations purposes described above. Please make this request in writing to the Center's Health Information Manager.

Request confidential communications from us. We will not disclose your health information except as described in this Notice. However, you may ask us to contact you by another means or at a different address or to limit the number or type of people who have access to your health information. Please make this request in writing to the Center's Health Information Manager.

Receive a paper copy of this Notice from us. You may request a copy of this Notice at any time.

YOUR RIGHT TO COMPLAIN

Complaints: If you believe that your privacy rights have been violated, you may file a complaint with the Center or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing, and all complaints will be investigated.

CHANGES TO THIS NOTICE

Changes to This Notice. We reserve the right to change this Notice at any time. We will post a copy of the current notice in the Center with the effective date in the upper right hand corner of the first page. You may request a copy of the current notice each time that you visit the Center for services or by calling the Center and requesting that the current notice be sent to you in the mail.

Patient Initials________________