New Patient Registration Packet

Date:	**Date of Birth:**	**Social Security Number:**
Patient Full Name:		
Address:		
City:	**State:**	**Zip Code:**

Home Phone:		**Cell Phone:**	**Relative Phone:**
Best time to reach you:		Day: Night:	**Email Address:**
Gender:	☐ Male	☐ Female	**Age:**
Emergency Contact Name:			**Emergency Contact Number:**
Are you a smoker?		☐Yes ☐ No	

Marital Status:	☐ Married	☐ Widowed	☐ Single	☐ Separated	☐ Divorced ☐ Life Partner
Student Status:	☐ Fulltime	☐ Part-time	☐ Not a Student		**Veteran Status:** ☐ Yes ☐ No

Homeless Status:	☐ Not Homeless ☐ Doubling Up ☐ Shelter ☐ Street ☐ Transitional	
Migrant Worker Status:	☐ Migrant ☐ Not a Farm Worker ☐ Seasonal	
Language Barrier:	☐ Yes ☐ No	**Your primary spoken language:**

Race:	☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Samoan ☐ Black/African American ☐ American Indian/Alaska Native ☐ White ☐ More than one race ☐ Unreported/Chose not to disclose race
Ethnicity:	☐ Chicano ☐ Cuban ☐ Mexican ☐ Mexican American ☐ Not Hispanic or Latino ☐ Puerto Rican ☐ Another (Hispanic or Latino) ☐ Declined to specify

Number of family members in household:	
How did you hear about CHDC?	

********State your household income in one of the following categories listed below********				
Household Income:	Weekly:	Biweekly:	Monthly:	Yearly:

<u>Financial Responsibility</u>

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with Community Health and Dental Care. Although we will compile the necessary forms to file to your insurance company it is the responsibility of the patient to dispute any services not covered by the insurance company.

I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement

_____ _____

Patient/Guardian Signature **Date**

Patient Name:	**Date of Birth:**

Patient Insurance Information

Leave sections blank if they do not apply

MEDICAL INSURANCE

Primary Medical Care Provider:	
Primary Medical Insurance Coverage:	
Subscribers Name:	**Relationship to Patient:**
Group Number:	**ID Number:**

Secondary Medical Insurance Coverage:	
Subscribers Name:	**Relationship to Patient:**
Group Number:	**ID Number:**

DENTAL INSURANCE

Primary Dental Provider:	
Primary Dental Insurance Coverage:	
Subscribers Name:	**Relationship to Patient:**
Group Number:	**ID Number:**

Secondary Dental Insurance Coverage:	
Subscribers Name:	**Relationship to Patient:**
Group Number:	**ID Number:**

VISION INSURANCE

Primary Vision Provider:	
Primary Vision Insurance Coverage:	
Subscribers Name:	**Relationship to Patient**
Group Number:	**ID Number:**

Secondary Vision Insurance Coverage:	
Subscribers Name:	**Relationship to Patient:**
Group Number:	**ID Number:**

Patient Name:	**Date of Birth:**

AUTHORIZATION OF TREATMENT/ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/PRIVACY NOTICE

PATIENT:	DOB:	DATE:

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize CHDC (Community Health and Dental Care, Inc.), its health practices and providers including physicians, dentists, integrated behavioral health providers, medication assisted treatment team, technicians, nurses, and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending health practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations or procedures.

PRIVACY NOTICE: I acknowledge receipt of the Health Information Privacy Notice for Community Health and Dental Care, Inc.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized health benefits is made on my behalf directly to the CHDC provider of service(s) furnished to me. I authorize CHDC to release any health information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employ er's or group health insurance plan, directly to CHDC. I hereby authorize that photocopies of this form to be valid as the original.

PAYMENT GUARANTEE: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided t o me through CHDC health practices and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of a CHDC billing statement whether it is an interim or final bill. In the event that I fail to make full payment or fail to comply with other payment arrangements made with CHDC's approval, I understand that appropriate collection measures may be initiated.

ELECTRONIC HEALTH RECORD: Healthcare providers require access to patient health information whenever or wherever a patient presents for care to assure safety, quality and to coordinate patient care across the provider network, avoiding duplication of services. CHDC has a system-wide electronic health record that is available to caregivers on a "need to know" basis, to share information about patient care provided in the hospital, outpatient or physician office settings. Confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS or drug or alcohol problems is maintained per relevant governmental and regulatory standards. Patient care summaries are automatically sent to designated CHDC and other community primary care/family/referring physicians, as well as to physicians who are consulted by the attending physician for coordination of care. CHDC and/or the attending physician can furnish and release to federal and state healthcare oversight agencies, or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named including copies of the medical record.

PATIENT PORTAL: Access to the secure patient portal is an optional service which I may suspend or terminate it at any time for any reason. I understand that my access to the patient portal will not affect the level of care that I receive. I understand that it is my responsibility to notify CHDC if there is a change in my email account or if I feel that my secure password has been breached.

ELECTRONIC PRESCRIBING: I understand that CHDC health practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my CHDC providers and my pharmacy. I have been informed and understand that CHDC providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my CHDC providers to see this health information.

IMMUNIZATION REGISTRY: I understand that CHDC participates in the Pennsylvania Department of Health's statewide immunization registry that collects vaccination history and information to serve the public health goal of preventing the spread of vaccine preventable diseases. The
registry complies with federal health information privacy laws.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I have been made aware and understand that all CHDC health practices and offices provide no facilities for safekeeping of valuables. I do hereby release CHDC from any responsibility due to loss or d amage of any valuables that I, or anyone accompanying me, may bring to a CHDC health practice, office or facility.

PERMISSION TO FAX CHILDHOOD IMMUNIZATION RECORD TO SCHOOLS: I do hereby grant permission for CHDC to send or fax childhood immunization records to schools, upon request.

Consent to Electronic Communication

I consent and authorize Community Health and Dental Care and its related entities, agents, contractors, including but not limited to schedulers, billing, and other staff to use automated telephone dialing systems, SMS text messaging, and electronic mail to (1) provide messages (including pre-recorded messages or text messages) to me about my account, payment due dates, missed payments, information for or related to medical goods and/or services provided, exchange information, changes to health care law, health care coverage, care follow-up, and other healthcare information or (2) provide messages (including pre-recorded messages) during a call or via text message that delivers a 'health care' message made by, or on behalf of, a 'covered entity' or its 'business associate' as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103. I understand that I may opt out by calling Community Health and Dental Care at 610-326-9460

HEALTH INFORMATION EXCHANGES: CHDC may make your health information available electronically through a state, regional, or national Health Information Exchange (HIE) service or through *NextGen Share* ® Network to facilitate the secure exchange of your health information between and among several health care providers or other health care entities for your treatment, payment, or other healthcare operations purposes. This means we may share information we obtain or create about you with a HIE, which will be made available to outside entities (such as hospitals, doctors offices, pharmacies, or insurance companies) or we may receive information they create or obtain about you (such as medication history, medical history, or insurance information) so each entity can provide better treatment and coordination of your healthcare services. In cases where your specific consent or authorization is required to disclose certain health information to others, we will not disclose that health information without first obtaining your consent. Information that requires additional consent in order to be shared includes psychotherapy notes, treatment for substance or alcohol abuse, and records of tests or treatment for sexually transmitted diseases.

We also participate with the Health Share Exchange (HSX), which is a non-profit organization responsible for facilitating data sharing between healthcare providers. For example, if you were to visit an unfamiliar Emergency Department, the ED doctor will be able to access your health record to see your medical history, including allergy information. Access to your health information during an emergency situation can be life-saving, especially if you are unconscious, and unable to relay your important health information to the doctor. If for any reason you are uncomfortable with this type of data sharing, you have the option to opt out. ***This is your responsibility***. Note: if you choose to opt out of HSX, then it is important for you to know that your information will not be available to view, even in emergency situations.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested .

_____

Signature of Patient or Parent or Legal Guardian/Authorized Representative

_____ _____

Printed Name Date

_____

CHDC Representative

CHDC Health Information Communication Preferences

PATIENT: _____ DOB: _____ DATE:_____

As our patient, we may need to reach you when you are not in the practice. For your privacy, please indicate your preferred method for us to communicate confidential health information, such as test or lab results, to you and/or others involved in your care. Please note that "appointment reminder telephone calls" may be left at the contact number(s) you list below. Please list your email address to receive online health care educational programs ordered by your care provider.

PLEASE INDICATE YOUR COMMUNICATION PREFERENCES BELOW:

☐ Give permission to leave health information pertaining to me, my dependent or child, at the numbers listed below:

Method	Yes	No	Area Code, Phone #, Ext., Email
Home Telephone	☐	☐	
Answering Machine	☐	☐	
Work Phone	☐	☐	
Cell Phone	☐	☐	
Email for our Patient Portal Secure Email Registration	☐	☐	
Email to Receive Provider-Ordered Online Patient Education Programs	☐	☐	

Without specific permission, we will **not** release any health information to anyone other than you. In some cases you may wish for another person to have access to your health information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner etc.):

☐ Do not release health information to anyone other than myself.

☐ I give permission to release health information pertaining to me to the individuals listedbelow.

Name	Relationship (i.e. spouse, parent, son, daughter, etc.)	Area Code, Phone # - Extension

Comments

I assume responsibility to inform the practice of changes in my phone number(s) or my preferences or to revoke this specific health information authorization at any time.

_____ _____

Signature of Patient or Patient's Legal Representative Date

_____ (Please Print Name) **CHDC Representative**_____

Outreach Consultation Form

As a patient of Community Health & Dental Care, you are eligible to receive **FREE** assistance from our team of highly experienced Patient Case Manager. Please review the following list of services and provide your signature to acknowledge receipt. If you would like to consult with one of our Case Coordinators, please indicate below:

Families

- ☐ Medicaid
- ☐ CHDC Dispensary Services
- ☐ Chip
- ☐ CHDC Health Care Discount Application (Sliding Fee)
- ☐ Enrollment Services (Choosing an HMO and CHDC as PCP)
- ☐ CCIS (Child Care Information Service, subsidized child care)
- ☐ SNAP (Supplemental Nutritional Assistance Program)
- ☐ Cash Assistance
- ☐ School Meals (Assistance)
- ☐ ERAP (Emergency Rental Assistance Program)
- ☐ LIHEAP (Low Income Heating Assistance Program)
- ☐ LIHWAP (Low Income Household Water Assistance Program)
- ☐ Healthy Women (Free mammograms, clinical breast and pelvic exams, and PAP tests)
- ☐ Pennsylvania's Health Insurance Marketplace (PENNIE)
- ☐ Referrals to Mental Health and Substance Abuse Treatment Options
- ☐ Literacy Council of Montgomery County, Chester County, and Berks County
- ☐ Legal Aid
- ☐ WIC (Women Infant Children)
- ☐ Laurel House (Domestic Violence)
- ☐ Safe Haven (Adoptive Service)
- ☐ CADCOM (Assistance with Utility Services)
- ☐ Housing Referrals
- ☐ CHDC Patient Transportation Assistance Program (Free transportation for our patients)
- ☐ TransNet, Barta, Rover (Medical assistance Transportation Program
- ☐ PAP (Patient pharmaceutical assistance program)
- ☐ "New Eyes" (free eyewear: frames and lenses)

Adults

- ☐ Aging and Adult referrals
- ☐ Medicare Advantage Plans
- ☐ Medicare Part D (Prescription Drug Coverage)
- ☐ Support Services Waiver Referrals
- ☐ AIDS Waiver Program
- ☐ Pace
- ☐ Pace-Net

Would you like to schedule an appointment with a Patient Case Manager? **Y / N**

Patient Signature:

Patient Name:	**Date of Birth:**

Community Health and Dental Care, Inc.

Healthcare Discount Application

Please fill out the application completely and attach all income information.

PERSONAL INFORMATION

Last Name:	First Name:
Date of Birth:	Social Security Number:
Home Address:	Home Phone Number:
	Cell Phone Number:
City/State/Zip:	Email:

HOUSEHOLD INFORMATION - List household members claimed on tax form (1040, 1040A and/or 1040EZ) and/or other forms

NAME	SOCIAL SECURITY NO.	DATE OF BIRTH	RELATIONSHIP

Please check the statement that best describe your housing situation:

- ☐ I live in my home which I rent, lease or own
- ☐ I live with family members and do not have any housing costs
- ☐ I am staying with a series of friends and/or extended family members on a temporary basis
- ☐ I am staying is supportive or transitional housing (such as a sober living facility or recovery home)
- ☐ I live in a public or private facility that provides temporary shelters (such as a shelter, mission, single room occupancy facility or motel)
- ☐ I have been released from an institution (such as jail or hospital) without stable housing to return to
- ☐ I live on the streets, in a car, park, sidewalk, in an abandoned building or any unstable or non-permanent situation
- ☐ I live in a foster care environment

Circle the amount that is closest to your household income

$12,000	$13,500	$15,000	$16,500	$18,000	$19,500	$21,000	$22,500	$24,000	$25,500
$27,000	$28,500	$30,000	$31,500	$33,000	$34,500	$36,000	$37,500	$39,000	$40,500
$42,000	$43,500	$45,000	$46,500	$48,000	$49,500	$51,000	$52,500	$54,000	$55,500
$57,000	$58,500	$60,000	$61,500	$63,000	$64,500	$66,000	$67,500	$69,000	$70,500
$72,000	$73,500	$75,000	$76,500	$78,000	$79,500	$81,000	$82,500	$84,000	$85,500

I have completed this application for healthcare discount eligibility and confirm that all my information is correct to the best of my knowledge. I understand a minimum payment of $20.00 for Medical/Vision/BH, $35.00 for Dental Services and $5.00 for Dispensary will be collected at the time of each visit. I understand that discounts are available regardless of my insurance status and if I do not qualify for a discount, I will be responsible to pay 100% of billed charges. For example, if I am eligible for an 80% discount I will be responsible for 20% of the applicable charges. I am aware that this discount does not apply to Dental and Medical lab fees. I understand for self-declared individuals that my slide discount may change subject to administrative approval.

☐ Community Health and Dental Care has offered and explained to me the benefits of applying for the healthcare discount. At this time I choose not to apply for the healthcare discount. I understand that I may apply at any time should I change my mind or my personal situation changes such as household size, insurance status and/or gross income.

APPLICANTS SIGNATURE:_____ Date: _____

DO NOT FILL OUT BELOW THIS LINE -ELIGIBILITY INFORMATION – FOR OFFICE USE ONLY

PROOF OF INCOME

☐ Most recent Income Tax Returns (1040, 1040A, 1040EZ; applicable adjusted gross income line)
☐ Two recent pay stubs (check one) ___Weekly___Biweekly___Monthly
☐ Social Security/Disability letters
☐ Proof of Residency

☐ Other: _____

Annual Gross Income $ _____ Family Size: _____

Patient discount applied to applicable charges:

Medical/Vision Discount: ☐ 100% ☐ 80% ☐ 60% ☐ 40% ☐ 20% ☐0%
Dental Discount: ☐ 100% ☐ 70% ☐ 55% ☐ 40% ☐ 25% ☐0%
Dispensary Discount: ☐ 100% ☐ 80% ☐ 60% ☐ 40% ☐ 20% ☐0%

Processed by:_____ Date: _____