



PATIENT INFORMATION					
Last Name:		First Name:		MI:	Birth Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Mailing Address:			City, State:	Birth date: / /	
Home Phone: ()		Cell Phone: ()		Email Address:	
Race (Circle One) White/ Black or African American/ Multi-racial/ American Indian or Alaska Native Asian/ Asian Indian/ Hawaiian or Pacific Islander/ Other Pacific Islander not Hawaiian Chinese/ Filipino/ Korean/ Vietnamese/ Other Asian/ Guamanian or Chamorro Samoan/ Other				Are you Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please further specify (circle one): Mexican/Mexican American/ Chicano/ Puerto Rican Cuban/ Other Hispanic or Latino Origin	
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:			Interpreter Required? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Care Physician:		Primary Dental Provider:		Do you need information on Advance Directives? <input type="checkbox"/> Yes <input type="checkbox"/> No	
GUARANTOR INFORMATION					
Name of Responsible Party:		Birth date: / /	Relationship of Responsible Party to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Caregiver <input type="checkbox"/> Other:		
Address (if different than patient):			City, State:		Zip Code:
Home Phone: ()		Cell Phone: ()		Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No	
EMERGENCY CONTACT					
Name of local friend or relative:		Relationship to Patient:		Home Phone: ()	Cell Phone: ()
INSURANCE					
(Please provide complete insurance information regardless of type of service utilizing. Provide all cards to the front desk.)					
Primary <u>Medical</u> Insurance: <input type="checkbox"/> Uninsured <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private/Commercial:					
Subscriber Name:		Date of Birth:		Policy/ID Number:	
Secondary <u>Medical</u> Insurance: <input type="checkbox"/> Uninsured <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private/Commercial:					
Subscriber Name:		Date of Birth:		Policy/ID Number:	
Primary <u>Dental</u> Insurance: <input type="checkbox"/> Uninsured <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private/Commercial:					
Subscriber Name:		Date of Birth:		Policy/ID Number:	
Secondary <u>Dental</u> Insurance: <input type="checkbox"/> Uninsured <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private/Commercial:					
Subscriber Name:		Date of Birth:		Policy/ID Number:	
AS A FEDERAL FACILITY WE ARE REQUIRED TO ASK THE FOLLOWING QUESTIONS					
ANNUAL INCOME - Locate your family size and circle the income range in that row that best fits your household.					
Although we are not a free clinic, we offer discounted (nominal) fees to eligible patients. Providing the below can help us determine eligibility for such programs.					
Family Size					
1	\$0 - \$15,960	\$15,961 - \$23,940	\$23,941 - \$27,930	\$27,931 - \$31,920	\$31,921 and up
2	\$0 - \$21,640	\$21,641 - \$32,460	\$32,461 - \$37,870	\$37,871 - \$43,280	\$43,281 and up
3	\$0 - \$27,320	\$27,321 - \$40,980	\$40,981 - \$47,810	\$47,811 - \$54,640	\$54,641 and up
4	\$0 - \$33,000	\$33,001 - \$49,500	\$49,501 - \$57,750	\$57,751 - \$66,000	\$66,001 and up
5	\$0 - \$38,680	\$38,681 - \$58,020	\$58,021 - \$67,690	\$67,691 - \$77,360	\$77,361 and up
6	\$0 - \$44,360	\$44,361 - \$66,540	\$66,541 - \$77,630	\$77,631 - \$88,720	\$88,720 and up
7	\$0 - \$50,040	\$50,041 - \$75,060	\$75,061 - \$87,570	\$87,571 - \$100,080	\$100,080 and up
8	\$0 - \$55,720	\$55,721 - \$83,580	\$83,581 - \$97,510	\$97,511 - \$111,440	\$111,440 and up
By signing below I agree that the above information is accurate and true to the best of my knowledge:					
Patient/Guardian Signature:				Date:	

GENERAL POLICIES AND CONSENTS

APPOINTMENT TIMES

It is important you show up to all appointments on time. All **new patients** are required to check in at least 30 minutes prior to their appointment. All **established patients** must check in at least 15 minutes prior to their appointment. This will allow time to complete all necessary paperwork and allows the staff to get the patient in the exam room by the actual appointment time. This will allow for a much smoother and timely visit. Failure to check in timely may result in the need to be rescheduled.

All minors (children age 17 and under) must be accompanied by a parent or legal guardian at all appointments.

MISSED APPOINTMENTS

Our missed appointment policy is strictly enforced as we truly desire to provide timely, quality care to our patients, but this becomes difficult when patients miss scheduled appointments. A missed appointment includes any appointment for which the patient does not present to the designated clinic/location, an appointment not cancelled/rescheduled at least 24 hours in advance and showing up late necessitating a reschedule.

We value family here and understand that it is often easiest to schedule all appointments on the same day. If you miss appointments scheduled for multiple family members, each family member will only be given appointments on different days in the future. If a child is requiring treatment, it is important to keep these appointments so they can receive necessary care. Failure to bring a child for treatment is considered neglect. CHCCMO is required to report suspected cases of neglect.

In the event of excessive missed appointments, CHCCMO has the right to grant care on an emergency or walk in basis only. For dental patients, please refer to the Dental Consents for further information on policies specific to dental.

FINANCIAL AGREEMENT

Payment is expected at the time of service. If insurance has been provided, you are hereby authorizing CHCCMO to release health information necessary to process your claims. In addition, you are also authorizing payment for insurance benefits to be paid directly to CHCCMO. You understand that you are responsible for any copays, coinsurance, deductibles, or non-covered services.

CONSENT TO TREAT

I understand my provider will recommend a treatment plan aimed at improving my health and wellbeing. By signing below, I consent to receiving care considered advisable from a CHCCMO provider. Such treatment may include, but is not limited to, examination and basic diagnostic testing. I understand that noncompliance with recommended treatment could result in worsening of my condition or an increased risk of complications. I attest that I have the legal authority to make health care decisions and act on behalf of the patient if the patient is a minor or otherwise incapacitated.

PATIENT CONDUCT

CHCCMO is committed to providing a safe environment for all patients, employees and visitors. Violent, aggressive, or verbally abusive behavior will not be tolerated and may result in removal from the premises.

PERSONAL VALUABLES

I recognize that CHCCMO is not responsible for any personal property brought onto CHCCMO's premises.

I have read and fully understand the policies and consents included on this form.

PATIENT, PARENT OR LEGAL GUARDIAN SIGNATURE

DATE

HEALTH INFORMATION EXCHANGE CONSENT

The Health Information Exchange (HIE) allows multiple healthcare provider to link by electronic medical records. When going to an outside healthcare provider, Community Health Center of Central Missouri may be able to share and/or obtain my medical records through the HIE. All providers must have sufficient personal information to prove they have a treatment relationship with you as a patient before the HIE will allow access to information. An HIE is important because sharing information improves care.

Community Health Center of Central Missouri Partners with the following HIEs:

- Tiger Institute Health Information Alliance
- Carequality/SureScripts

You can choose to if you want to participate in the HIE. The care you receive from providers at CHCCMO is not dependent on whether you choose to participate in the HIE. With this form you may choose from 2 options:

Option 1 - Opt In

I hereby authorize Community Health Center of Central Missouri to RELEASE and OBTAIN all of my medical records and medical information, including records which relate to any physical or mental condition, psychological condition, psychiatric evaluation and treatment, psychotherapy, counseling, drug addition, infection status, HIV/AIDs, genetic testing, or treatment for drug or alcohol abuse, even though such information is protected by federal law, to the above HIEs.

The purpose of this disclosure is for healthcare treatment purposes, change in providers and continuity of healthcare. I specifically authorize the release of my medical information to and from the above HIEs in an electronic format.

Option 2 - Opt Out

By signing this form you acknowledge that you understand the statements below:

- I understand that I am signing this form because I do not want my health records shared with my providers and health care team members through the HIEs listed above.
- I understand that this opt-out form only applies to the HIEs listed above that Community Health Center of Central Missouri participates in and does NOT cover or affect my opting out of any other HIE.
- I may choose to join the HIEs that Community Health Center of Central Missouri participates in at any time by signing an HIE Request to Opt-In form.
- I understand that by opting out of the above HIEs, my providers will not have immediate access to critical information about my health accessible through these HIEs. This may impact my provider's ability to see a complete picture of my health which could limit their ability to make the best possible decisions about my care.
- This request can take up to 3-5 business days to take effect.

Opt In – I choose to Opt-in to the HIE; I give consent for CHCCMO to share all health information through the HIE.

This authorization is valid until revoked by me in writing, and it will be effective the date received.

Opt Out – I am choosing to Opt-out of the HIE; I am requesting none of my health information be shared through the HIE.

PATIENT, PARENT, OR LEGAL GUARDIAN SIGNATURE

RELATIONSHIP TO PATIENT

DATE

WITNESSED BY

DATE



Community Health Center of Central Missouri

HIPAA AGREEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I understand I can request a copy of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Please list below any individuals you would like to have access to your medical records. Anyone who is not listed on this form will be unable to access any information about your healthcare.

I, _____, give my permission for the Community Health Center staff to discuss all health information with:

Name	Relationship to patient

Name (Print): _____ **Relationship to Patient:** _____

Signature: _____ **Date:** _____

Patient Name: _____

DOB: _____

MEDICAL PATIENT HISTORY

Medications

Preferred Pharmacy: _____

List any current medications (including over the counter, vitamins, and birth control)

Are you currently being treated by another provider with any of these medications? Yes No

If yes, please list the provider(s): _____

Allergies

No Known Allergies

List any allergies and the allergic reaction.

Medical History

Place a checkmark next to any of the below conditions you have a history of and indicate the year diagnosed if known.

- | | | |
|---|---|---|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Osteoporosis _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> High Cholesterol _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Anxiety _____ | <input type="checkbox"/> Gallbladder Disease _____ | <input type="checkbox"/> Seizure Disorder _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Acid Reflux _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Headache, migraine _____ | <input type="checkbox"/> Thyroid Disease _____ |
| <input type="checkbox"/> Benign Prostatic Hypertrophy _____ | <input type="checkbox"/> Heart Trouble _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Blood Clots _____ | <input type="checkbox"/> Hepatitis/liver disease _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High Blood Pressure _____ | |
| <input type="checkbox"/> COPD _____ | <input type="checkbox"/> Irritable Bowel Disorder _____ | |
| <input type="checkbox"/> Depression _____ | | |

Surgical History

Place a checkmark by any surgery you have had and the year performed.

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Stent _____ | <input type="checkbox"/> Gallbladder Removed _____ | <input type="checkbox"/> Joint Surgery (ORIF) _____ |
| <input type="checkbox"/> Appendix Removed _____ | <input type="checkbox"/> Colon Removed _____ | <input type="checkbox"/> Thyroidectomy _____ |
| <input type="checkbox"/> Arthroscopy _____ | <input type="checkbox"/> Colon Surgery _____ | <input type="checkbox"/> Tonsillectomy _____ |
| <input type="checkbox"/> Back Surgery _____ | <input type="checkbox"/> Gastric Bypass _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Blood Transfusion _____ | <input type="checkbox"/> Hernia Repair _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Heart Bypass _____ | <input type="checkbox"/> Hip Replacement _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cardiac Pacemaker _____ | <input type="checkbox"/> Hysterectomy _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Carpal Tunnel Release _____ | <input type="checkbox"/> Knee Replacement _____ | |
| <input type="checkbox"/> Cataract Extraction _____ | <input type="checkbox"/> LASIK _____ | |

Continued on next page....

Patient Name: _____

DOB: _____

Family

Father Alive and Well Deceased – Cause? _____

Mother Alive and Well Deceased - Cause? _____

Has any blood relative ever had? (Check and list who)

ADD/ADHD _____

Alcoholism _____

Allergies _____

Alzheimer's _____

Asthma _____

Blood Disorder _____

Cancer _____

Depression _____

Developmental Delay _____

Diabetes _____

Eczema _____

High Cholesterol _____

Genetic Disease _____

Hearing Deficiency _____

Heart Trouble _____

High Blood Pressure _____

Irritable Bowel Disease _____

Learning Disability _____

Mental Illness _____

Migraines _____

Obesity _____

Osteoporosis _____

Kidney Disease _____

Seizures _____

Stroke _____

Thyroid Disorder _____

Diagnostic/Screening Studies

If you have had any of the following performed, indicate the most recent date/year performed and where performed.

Mammogram _____

Colonoscopy _____

Pap Smear _____

Other: _____

Females Only: Last Menstrual Period __/__/__

Social

Tobacco Use (Check One) Ex-Smoker Never Used Current Use

Indicate form of tobacco and how often used i.e. daily, occasional (skip if not a current user)

Cigarettes _____ How many packs per day? _____

Chewing _____

Cigarette _____

Smokeless _____

Cigar _____

Snuff _____

Pipe _____

Other: _____

Electronic Cigarette

Alcohol Use No Yes - Frequency Daily Weekly Monthly Occasionally Rarely

Recreational Drug Use No Yes - Marijuana Methamphetamine Cocaine Heroin Opiates Other: _____