COMMUNITY HEALTH PARTNERS

REGISTRATION FORM: *Please Print*

Complete ALL sections.

Missing information may result in charges billed directly to the patient.

PATIENT INFORMATION - PAGE 1

Last Name: First Name: Middle Name:

Also known as or maiden name:

Marital Status: 0 Single 0 Married 0 Widow **Date of Birth:** Age:

Sex: 0 **M** 0 **F** 0 **Prefer not to specify Social Security #:***

Race: 0 Black/African American 0 White/Caucasian 0 Native Hawaiian/Other Pacific Islander
0 American Indian/Alaska Native 0 Asian 0 Unknown 0 Other or Prefer not to specify

Ethnicity: 0 Hispanic 0 Non-Hispanic 0 Prefer not to specify

Preferred Language: 0 English 0 Spanish 0 Hmong 0 Lao 0 Punjabi 0 Hearing Impaired/Sign
0 Vietnamese 0 Other 0 Prefer not to specify

Preferred Phone #: 0 Home 0 Cell 0 Work

Second Phone #: 0 Home 0 Cell 0 Work

Street Address: P.O. Box/Apt #:

City: State: Zip Code:

E-mail Address:

Employer: Phone #:

Primary Care Physician: Phone #:

Did a Physician refer you to this office or did you choose this office yourself? 0 Physician 0 Self

If a Physician, please state who:

Preferred Pharmacy: Phone #:

Pharmacy Location/Cross Streets:

INJURY INFORMATION - Date of Injury:

Work Related Injury: 0 Yes 0 No

IN CASE OF AN EMERGENCY

Emergency Contact: Relationship to Patient:

Home Phone #: Work Phone #:

***** *Community Health Partners' electronic medical record system (EMR) requires your social security number as your unique identification number. Please help us provide you with the highest quality of care by sharing your social security number. This is very important because without your social security number as an identifier, your electronic medical record may not be complete or may contain inconsistencies. Please be confident your social security number is used only used for this purpose — it is never printed out. It is protected from misuse just as we protect your health information.*

COMMUNITY HEALTH PARTNERS

REGISTRATION FORM: *Please Print*

Complete ALL sections.

Missing information may result in charges billed directly to the patient.

PATIENT INFORMATION - PAGE 2

Last Name: First Name: Middle Name:

INSURANCE INFORMATION - *Please give your insurance card to the receptionist.*

Guarantor Information: 0 ***Check here if same as patient***

Responsible Party: Date of Birth:

Address (*if different from patient*): Home Phone #:

Occupation: Employer:

Employer Address: Phone #:

PRIMARY INSURANCE - Insurance Company Name:

Subscriber's Name: Subscriber's SS #:

Date of Birth: Group #: Policy #:

Co-pay: $ Patient's relationship to subscriber: 0 Self-01 0 Spouse-02 0 Child-03 0 Other:

SECONDARY INSURANCE (*IF APPLICABLE*) - Insurance Company Name:

Subscriber's Name: Subscriber's SS #:

Date of Birth: Group #: Policy #:

Patient's relationship to subscriber: 0 Self-01 0 Spouse-02 0 Child-03 0 Other:

Is this a worker's compensation claim: 0 Yes 0 No

Medicare Secondary Reason Code (Must check one if Medicare is Secondary):

0 12 **Working Aged** Beneficiary or Spouse with Employer Group Health Plan

0 13 End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan

0 14 No-fault Insurance including Auto is Primary

0 15 Worker's Compensation

0 16 Public Health Service (PHS) or Other Federal Agency (Government Research Program)

0 41 Black Lung

0 42 Veteran's Administration

0 43 **Disabled** Beneficiary Under Age 65 with Large Group Health Plan (LGHP—Employers with 50+ employees)

0 47 Other Liability Insurance is Primary (Homeowners)

What is your preferred method of communication for appointment reminders?

0 Phone 0 Regular Mail 0 Web Portal 0 Text Message 0 Do Not Contact

PRIVACY CLAUSE: A person is liable for constructive invasion of privacy when they attempt to capture, any type of visual image, sound recording, or other physical impression of another individual engaging in a personal or familial activity under circumstances in which that individual had a reasonable expectation of privacy. A person who violates these provisions would be subject to a civil fine of not less than $5,000 and not more than $50,000 [California Civil Code, Section 1708.8].

Community Health Partners complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Patient/Guardian Signature/ Print Name Date

COMMUNITY
HEALTH PARTNERS

Office Procedures and Consent

Shared Electronic Medical Records

We share an electronic medical records system with Community Medical Centers.

Smoke Free Environment

For the health of our patients, employees and visitors, smoking is not permitted at the Community Health Partners offices.

Weapon Free Environment

Weapons of any kind are not allowed at any of the Community Health Partners offices.

No Show/Appointment Cancellation Policy

We would like to provide you with outstanding service. This however requires your cooperation. If you are unable to keep a scheduled appointment, please call us at least 24 hours in advance so we can give this appointment to another patient. If you fail to keep an appointment or do not call at least 24 hours in advance, you are considered a "No Show" and a $ 35.00 charge may be billed directly to you since it is not covered by any insurance plan.

I have read, understand, and agree to the above No Show/Appointment Cancellation Policy.

_____ _____

Patient Signature (Guarantor if patient is a minor) Date

_____

Print Name

COMMUNITY HEALTH PARTNERS

Electronic Communication Exchange Consent

We offer electronic communication services via text messaging, email, and voice messaging to serve you better. Electronic communication is used for but not limited to:

- Appointment Reminders
- Patient Surveys
- General Health Tips

By providing my phone number (including a landline or a wireless phone number), I consent to receive calls (including autodialed calls and artificial or prerecorded messages) at that number form the clinic and its physicians, agents and independent contractors (including services agencies and collections agencies) regarding clinic/medical services and any related financial obligations.

Limitations on calls, if any:

_____

_____

If I want to revoke this consent, I agree to notify [insert the office/phone number/email address to receive revocations].

I will also notify this office if I relinquish any phone number I give to the clinic. I understand that I am not required to agree to sign the Electronic Communication Exchange Consent as a condition of receiving services at the clinic.

Please list the phone numbers and email addresses you permit use to use to contact you about appointments, patient surveys, and general health tips.

Cell Phone Number: _____

Land Line Number: _____

Email Address: _____

_____ _____

Patient Signature (Guarantor if patient is a minor) Date

_____

Print Name

Agreement and Authorization for Services Consent Form

I. Consent for Diagnosis and Treatment

I acknowledge and understand that, in presenting myself for treatment and medical care to Community Health Partners, I authorize and consent to the administration and performance of all tests and treatments which may be ordered by the physician (and/or designated assistant) and carried out by members of the Community Health Partners medical staff and personnel. I understand that some of my medical care can and will be accomplished via remote Telehealth (also known as Telemedicine) visits, and I consent to their use where deemed medically appropriate by Community Health Partners medical staff. I am aware that medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination.

II. Retention of Information

I understand that Community Health Partners may record medical and other information concerning my treatment in electronic and other physical form. Such information is required in the course of my treatment, and may be released by Community Health Partners for the purposes authorized on this form. I understand that portions of my records may be disclosed to qualified non-Community Health Partners personnel for the purpose of conducting scientific or statistical research, management or financial audits, licensure and program evaluation or other similar purpose. I will not be identified by name or other personally identifying information in any report of such research, audit or evaluation without my express written consent.

III. Release of Information

I hereby authorize Community Health Partners to release to my insurance companies, employer insurance groups, health plans, Medicare/Medicaid program, its insurance carriers or intermediaries any medical records or other information concerning this treatment to obtain reimbursement on my behalf for the treatment and services provided to me by Community Health Partners and the physicians associated with it. I may revoke my consent at any time for any reason by providing written notification to Community Health Partners. This authorization shall not conflict with any internal Community Health Partners policy regarding release of information which will have priority. This authorization is not intended to allow the release of records regarding my treatment for services requiring a specific authorization under State or Federal Law.

IV. Teaching Program

I understand that appropriately supervised residents, interns, medical students, students of ancillary health care professions (e.g. nursing, xray, and rehabilitation therapy), post-graduate fellows, and other trainees may observe, examine, treat and participate in my care as part of educational programs.

COMMUNITY HEALTH PARTNERS

Agreement and Authorization for Services Consent Form

V. Assignment of Benefits and Agreement to Cooperate in Collection Efforts

In consideration of the healthcare services provided to me by Community Health Partners, I hereby assign Community Health Partners, physicians, and other professionals associated with Community Health Partners all of my rights and claims for reimbursement under Medicare, Medicaid, or group accident or health insurance policy for which benefits may be available for payment of the services provided. In addition, I hereby agree to personally cooperate with, and take all steps necessary, required or reasonably requested by any reimbursement source to effectuate, perfect, confirm or validate my assignment and authorization of Community Health Partners as my assignee and authorized representative, and to assist Community Health Partners with pursuing payment from any reimbursement source.

VI. Guarantee of Payment

I understand and agree that I am financially responsible for any and all charges related to any services rendered. While my claims may be paid by the above-mentioned coverage sources, I recognize that payment is not guaranteed and that I am ultimately responsible to pay Community Health Partners, physicians, and other professionals associated with Community Health Partners the balance due of all charges not paid for by the above mentioned coverage (excluding those charges not collectible pursuant to Medicare regulation). This may include costs of collection and/or reasonable attorneys' fees.

I have read each of the foregoing, I-VI and fully agree to each of the statements and agreements herein, which may include inpatient treatment after emergency or outpatient care, by signing below as my free and voluntary act.

_____ _____

Patient Date

_____ _____

Guardian if patient is under 18 years old Date

_____ _____

Other (record relationship to patient) Date

_____ _____

Witness Date

COMMUNITY
HEALTH PARTNERS

Financial and Billing Policies

Thank you for choosing the physicians at Community Health Partners. We are committed to clinical excellence in meeting your health care needs. We participate with a variety of insurance plans and will directly bill your insurance under these plans.

We understand that billing and payment for health care services can be confusing and complicated. It is important for you to know the information contained in your specific health plan, including any co-payments and other provisions. If you have any questions, call your health plan's member services department their number is listed in your benefit plan booklet or on your ID card.

Inform Us of Changes: If you are a current patient, please inform us if your personal or insurance information has changed since your last visit. The lack of current information may cause delays in care and responsibility for the cost of the entire visit.

Bring Your Health Information: Bring your health insurance information to your visit. This includes identification, all insurance cards, and authorization/referral forms. We will ask you to sign forms such as a release of information, assignment of benefits and possibly additional forms depending on your visit

Co-Payments, Deductibles and Co-Insurance: Co-pay's are due at time of your office visit. Under the terms of our contract with the various insurance plans we cannot waive any co-payments, deductibles or co-insurance amounts defined as patient responsibility. If you have any questions regarding your co-payments or deductibles, please call your insurance company. For your convenience we accept cash, checks, debit, VISA, and MasterCard.

Patient Responsibility Balances: All patient responsible balances must be paid in full or a financial arrangement must be made at the time of your visit.

Deposits: For certain procedures, you may be required to pay a deposit or pay for the service in full prior to treatment.

Prompt Payment: We offer a prompt payment discount. Please contact our Billing Department for details.

Prior Authorization: Most health plans require authorization for elective services. If your insurance company decides your service was not medically necessary, is pre-existing, or is not a covered service you will be asked to pay prior to the time of service.

HMO/Managed Care Plans: It is your responsibility to make sure a current referral has been obtained for your care with our providers. If a referral has not been obtained by your appointment you may need to reschedule your visit until you have a current referral. We realize this is an inconvenience, but without the referral our physician will not be reimbursed for the services provided.

Workers Compensation: Please bring your claim number, date of injury and employer/workers compensation information. Your claim needs to be open and valid for the condition that we are seeing you for.

Statements: You will not receive a statement until your primary insurance company has fulfilled its financial responsibility or a service is determined to be patient responsibility.

COMMUNITY
HEALTH PARTNERS

Financial and Billing Policies

Who Can Discuss a Bill: Confidentiality is important. Our Patient Account Representatives may only speak with the patient or the person designated in writing by the patient to receive the bill(s) on behalf of the patient.

I have read, understand, and agree to the above Billing Policies. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility. I authorize my insurance benefits be paid directly to Community Health Partners. I authorize Community Health Partners to release pertinent medical information to my insurance company when requested, needed to obtain authorization for a procedure or to facilitate payment of a claim. I have given complete and accurate information and agree to inform Community Health Partners of any changes regarding my personal billing information or my insurance billing information.

_____ _____

Patient Signature (Guarantor if patient is a minor) Date

_____

Print Name

Community Health Partners complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Your provider is a member of Community Health Partners medical foundation. That means that billing statements for services provided by your physician will come from and be processed by Community Health Partners medical foundation.

COMMUNITY HEALTH PARTNERS

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Community Health Partners Notice of Privacy Practices. I understand that the Notice of Privacy Practices describes how Community Health Partners may disclose and use my protected health information. I am encouraged to read the Notice of Privacy Practices in full.

Patient Name: MRN:

Date:_____ Time:_____ Signature:_____

Patient/Legal Representative/Guardian

If signed by the patient's representative/guardian, indicate:

1. a. Name of Signer: _____
2. b. Relationship to patient: _____

[ ] Decline to Sign Acknowledgement or Inability to Obtain Acknowledgement:

If acknowledgement is not signed, indicate reason not signed and efforts made to have acknowledgement signed:

[ ] Patient/representative/guardian declines to sign

[ ] Emergency condition prevented signature

[ ] Other, describe below

Print Name/Title: _____

Date:_____ Time:_____ Signature: _____

(CHP Employee)

Interpreter Signature if Applicable

I have accurately and completely read the foregoing document to

_____ in _____, the patient's or legal
(Patient or Legal Representative Name) (Language)

representative's primary language

(He/she) understood all of the terms and conditions and acknowledged (his/her) agreement thereto by signing the document in my presence.

_____ _____

Date / Time Interpreter Signature / Print Name / Title

Patient Label

COMMUNITY
HEALTH PARTNERS

Personal Representative

In the space below, if so desired, please indicate any personal representatives* or other individuals who are permitted to receive or know information concerning your healthcare for the period 12 months from the date you sign this form. If your designated personal representatives or other individuals change during the time this form is in effect, you must contact CHP in writing and request the change.

Name(s)_____

_____

_____

Patient Signature Date

**A personal representative as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is someone with the authority to make decisions related to your health care under applicable state law. Some examples of personal representatives include: an agent authorized to make medical decisions on your behalf in an advance health care directive, a court appointed legal guardian, or the parent or guardian or an emancipated minor.*

Community Health Partners (CHP) complies with applicable Federal civil rights law and does not discriminate on the basis of race, color, national origin, age, disability or sex.

NEW PATIENT | INITIAL CLINICAL HISTORY AND PHYSICAL FORM

Date:_____

Name:_____Age:_____Date of Birth: ____/_____/_____

Race: ☐African American ☐Asian ☐Caucasian ☐Hispanic ☐Multi-Racial Other_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed # of Children_____

Previous Family Physician:_____ReferringPhysician:_____

Past Medical History:

☐ None
☐ Heart Disease
☐ High Blood Pressure
☐ Stroke/TIA
☐ Obstructive Sleep Apnea
☐ Coronary Artery Disease
☐ Depression
☐ Anxiety
☐ Bleeding Difficulties
☐ Hepatitis A, B, or C
☐ HIV
☐ Diabetes-Diet Controlled
☐ Diabetes-Oral Meds
☐ Diabetes-On Insulin
☐ High Cholesterol
☐ Seizure
☐ Loss of Consciousness
☐ Arthritis (Type)_____
☐ Asthma
☐ Emphysema
☐ Osteoporosis
☐ Allergy-Food
☐ Allergy-Seasonal
☐ TB
☐ Hypothyroid
☐ Hyperthyroid

☐ Cancer: Type/Treatment:_____

☐ Other:_____

Past Surgical History (Type of Surgery & Year)

1. 2. 3.

4. 5. 6.

Prescription Medications (Name and MG)

1. 2. 3.

4. 5. 6.

Non-Prescription Medications (Name and MG)

1. 2. 3.

4. 5. 6.

Drug Allergies/Type of Reaction

☐ No known Allergies ☐ Latex ☐ Tape ☐ Other

1. 2. 3.

Social History:

(please check the appropriate listings)

Tobacco Use
☐Never
☐Quit/When_____
☐Cigarettes: ____Pack/Day
☐Pipe/Cigars
☐Chewing Tobacco

Alcohol Use
☐ None
☐ Socially
☐ Daily
☐ Heavy

Have you ever been treated for alcoholism?
☐ Yes, When?_____☐No

Drug Use
☐ None
☐ Marijuana
☐ Amphetamines
☐ Other _____

Have you ever been treated for drug use?
☐ Yes ☐No
If yes, when? _____

Exercise
☐ None
☐ 1-2x/week
☐ 3-4x/week
☐ 5-7x/week

Caffeine Use
☐ None
☐ Occasional
☐ Daily

Barriers to Care

This helps us identify what resources you may need in the future that can be addressed by our Care Coordinators & Oncology Support Services

Are there any religious beliefs that would affect your medical care? _____
Y or N Transportation Issues: If Yes, please explain: _____
Y or N Lack of Social Support: If Yes, please explain: _____
Y or N Financial Issues: If Yes, please explain: _____
Y or N Other: If Yes, please explain: _____

Advanced Care Planning: Do you have an Advance Care Plan/Health Care Directive? ☐Yes ☐No
Would you be interested in receiving more information about Advanced Care Planning? ☐Yes ☐No

Education (please check highest level)
☐Grade School ☐High School ☐College ☐Post Graduate

Occupational History

Employer: _____ Job Title: _____
Have you altered your job as a result of the problem you brought here today? ☐Yes ☐No

If yes, please explain: _____

If you're currently off work as a result of the problem, how long have you been off? _____

Family History

Father	☐ Living ☐ Deceased	Age:_____	Medical History or Cause of Death	☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐Cancer Type _____ ☐ Other
Mother	☐ Living ☐ Deceased	Age:_____	Medical History or Cause of Death	☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐Cancer Type _____ ☐ Other
Brothers	☐ Living ☐ Deceased	Age:_____	Medical History or Cause of Death	☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐Cancer Type _____ ☐ Other
Sisters	☐ Living ☐ Deceased	Age:_____	Medical History or Cause of Death	☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐Cancer Type _____ ☐ Other

For Females

Are you pregnant?_____ Are you breastfeeding? _____ # of pregnancies/deliveries _____ Type of birth control? _____

Date of first menstrual period: _____ Date of last menstrual period? _____

Last Mammogram _____ Last Pap: _____ Last Bone Density Scan: _____

For Males

Do you experience impotency? _____ Erectile Problems? _____

Immunizations: Flu Date: _____ Pneumonia Date: _____ Tetanus Date: _____ COVID Date:_____

Other: Screenings: _____ Colonoscopy: _____