PATIENTS INITIALS:_____ID: _____

Western North Carolina Community Health Services

PATIENT REGISTRATION FORM

Please return completed forms to the front desk

* INDICATES A REQUIRED FIELD — PATIENT INFORMATION

*Patient's Last Name | *Patient's First Name | Middle Initial | Preferred name | *Date of Birth | *Age

Email address | Home phone # | Mobile phone # | Social Security No.

*Mailing address | Apartment

*City | *State | *ZIP Code

Street address | Apartment

City | State | ZIP Code

*Preferred method of contact? Home Phone ☐ Mobile Phone ☐ Email ☐ Text ☐

*Have you previously been a patient here before? NO ☐ YES ☐

Marital status (select one)? Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

*How did you hear about us? Family / Friend ☐ DSS ☐ Health Dept. ☐ Private Physician ☐ Internet / Online ☐ Former Patient ☐ WNCCHS Employee ☐ Other ☐

*What is your race? Asian ☐ ~American Indian / Alaskan Native ☐ Black / African American ☐ White ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Choose not to disclose ☐

~*Persons who trace their origins to any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment.*

*What is your ethnicity? ☐ Latino / Hispanic ☐ Non-Latino / Hispanic ☐ Not Reported

Employment Status? Employed ☐ Unemployed ☐ Student ☐ Disabled ☐ Retired ☐

Sex at birth? Male ☐ Female ☐

Gender Identity? Male ☐ Female ☐ Transgender (Female to Male) ☐ Transgender (Male to Female) ☐ Genderqueer ☐ Choose not to disclose ☐

Sexual Orientation? Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Unknown ☐ Choose not to disclose ☐

ADDITIONAL INFORMATION

Pharmacy Name: _____ Location: _____

Do you have a healthcare power of attorney (POA)? YES ☐ NO ☐ If yes, please provide a copy

* INDICATES A REQUIRED FIELD — RESPONSIBLE PARTY

(Please complete for all patients under 18 years old)

Last Name, First Name | Relationship to patient | Social Security No. | Date of Birth

Last Name, First Name | Relationship to patient | Social Security No. | Date of Birth

* INDICATES A REQUIRED FIELD — IN CASE OF EMERGENCY

Emergency contact Name | Relationship to patient | Phone No. | Alternate Phone No.

*Information to release to contact? Complete Medical Records Appointment ☐ Financial / Billing ☐ Pharmacy Pick-Up ☐ Emergency Information ☐ Lab Results ☐ Examination ☐ Diagnosis ☐ My Treatment Other specific purpose ☐

Emergency contact Name | Relationship to patient | Phone No. | Alternate Phone No.

*Information to release to contact? Appointment ☐ Financial / Billing ☐ Pharmacy Pick-Up ☐ Emergency Information ☐ Lab Results ☐ Examination ☐ Diagnosis ☐ My Treatment ☐ Other specific purpose ☐ _____

Patients Signature (or legal guardian, if applicable) _____ Date _____

By signing, I confirm all my demographics are correct. Patient Signature (or Guardian): _____ Date: _____

Staff Initials: _____

Western North Carolina Community Health Services

PATIENT INSURANCE INFORMATION

Please present your insurance card each time you check-in

PRIMARY INSURANCE

Plan Name: _____ ID Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder Social Security #: _____ Sex: Male ☐ Female ☐

Policy Holder's Date of Birth : _____

Policy Holder's Employer : _____

SECONDARY INSURANCE

Plan Name: _____ ID Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder Social Security #: _____ Sex: Male ☐ Female ☐

Policy Holder's Date of Birth : _____

Policy Holder's Employer : _____

FINANCIAL INFORMATION

(Sign below if you have insurance)

WNCCHS requires payment on the day of service. This payment includes outstanding deductibles, co-payments, non-covered services, sliding fee payments and any charges remaining after insurance has made payment on your account. Please be advised that your insurance may not cover all of your charges and that you are responsible for any balance on your account and will be billed until that balance is paid. As a patient of WNCCHS, you may be eligible for discounted services. Money, or a lack of money, should never keep you from getting the care you need. Our services are available on an "ability to pay" basis, which means we consider your household income and family size and charge a nominal fee based on that information. We simply ask that you request a sliding fee scale application and provide accurate information for a review of eligibility. Thank you for choosing us as your healthcare partner. Signing of this form indicates you are aware of above policies and procedures and were advised of the sliding fee program. I hereby authorize assignment of all insurance benefits payable directly to WNCCHS.

If you have insurance coverage, most likely you are required by them to have all your lab testing done at a laboratory and testing company that has a contract with your plan. If your health care benefits do not cover clinical laboratory testing services, you will have to pay for the tests performed by LabCorp if specimen collection services performed.

Patient Signature (or Guardian): _____ Date: _____

Self-Pay (sign below if you do not have insurance)

Patient Signature (or Guardian): _____ Date: _____

Staff Initials: _____

Western North Carolina Community Health Services

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, _____ , hereby acknowledge receipt of the Notice of Privacy Practices given to me by Western North Carolina Community Health Services.

ACKNOWLEDGEMENT OF HEALTH INFORMATION EXCHANGE

The North Carolina Information Exchange (HIE) is a way of sharing patient health information among participating doctor's offices, hospitals, labs, radiology centers, and other health care providers. The purpose is to ensure that each caregiver has the most recent information available from other providers. WNCCHS has decided to participate in the most recent NCHIE as a means of sharing our patient data among other health care providers in the state of North Carolina and may participate in other exchanges as they become available. If you do not wish your information to be viewed by other providers, there are opt-out forms on the NCHIE's website that you may send directly to the NCHIE (www.hiea.nc.gov)

REFERRALS / OPTION TO CHOOSE

WNCCHS is a primary care provider and is not equipped to provide all medical services that may be appropriate for your medical care. In some cases, WNCCHS may recommend that you receive additional medical services, such as laboratory services, imaging services or specialty care from another healthcare provider. In the event that this 'does occur, please be advised that you may be required to pay on the day of service and/or be billed for any balance on your account with the referral provider.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Western North Carolina Community Health Services to release to my insurance carrier or its designated agents any information concerning medical care (physical and/or psychological), advice, treatment or supplies provided to me for the purposes of administration, review, investigation or evaluation of claim coverage and utilization of services.

I authorize that a copy of this information to be as valid as the original. I will notify WNCCHS in writing of any information I do not want released.

I acknowledge I have read the above statements.

Patient Signature (or Guardian): _____ Date: _____

Staff Initials: _____

Western North Carolina Community Health Services FQHC

NO SHOW ~ LATE ~ AND CANCELLATION POLICY

Any visit that the patient does not call and cancel/reschedule 24 hours prior to the appointment or the patient does not attend within a ten-minute grace period following the appointment time, the visit is considered a "No Show" appointment. While WNCCHS does not charge a fee for No Shows at this time, a future fee is possible. The policies and procedures for No Shows are currently be evaluated, and more stringent guidelines could be adopted in the future. If you have continued No Show appointments, you could be restricted for scheduling of future appointments.

Please be considerate of your medical providers time and call **828-285-0622,** in advance to let WNCCHS know if you cannot attend your scheduled visit.

I verify by my signature that I have read and understand the above information.

Patient Name (Printed): _____

Patient Signature (or Guardian): _____ Date: _____

CONSENT TO RECEIVE TEXT and/or EMAIL MESSAGES

WNCCHS would like to be able to communicate with you via email, and/or text for appointment reminders and/or to provide general health information about your care.

If at any time, I provide an email or text address at which I may be contacted, I consent to receive appointment reminders and other healthcare communications/information at that email or text messages from WNCCHS (**text message data rates may apply**). By initialing below, I consent to receive text messages from WNCCHS on my cell phone and any number forwarded or transferred to that number to receive communications as stated above. I understand that this request to receive emails and text messages will apply to all future appointments reminders/health information unless I request a change in writing (see revocation below).

The cell phone number I authorize to receive text messages and the email address I authorize to receive email messages for appointment reminders and/or general health reminders/information are as provided under patient information.

I authorize WNCCHS to leave detailed messages (including medical information or test results) on the voicemail at my contact number. YES ☐ NO ☐

I authorize WNCCHS to leave a call back number only. YES ☐ NO ☐

Revocation Use Only:
I hereby revoke my request to receive any future appointment reminders and general health information via text messages and or email
Patient/Patient Representative Signature: _____ Date: _____

Staff Initials: _____

PATIENT AGREEMENT

The patient named above agrees to **ALL** the terms and conditions listed below. My signature below certifies that I read (or someone read to me) this entire document, that I understand it, and that I have the legal authority to sign for the patient named above.

To tell us the patient's health history, including all health care providers (e.g., specialists) serving the patient **AND all medications/drugs (**prescribed and unprescribed) the patient is taking.

If something we tell the patient is not clearly understood by the patient or his/her legal guardian/ representative, to ask us to clarify until it is clearly understood.

To keep every scheduled appointment or reschedule before the appointment. A patient who has not come to the clinic in 12 months is deactivated. This means we cannot serve the patient again until he or she completes the new patient enrollment process (Intake).

To follow, to the best of the patient's ability, the agreed upon health care plan, or express concerns if unable to follow it.

To refrain from engaging in any of the prohibited behaviors listed below.

While on WNCCHS leased or owned property, possessing—with or without a license/permit—any type of fire arm.

Using, or attempting to use, physical force or violence against any individual—regardless of the means, e.g., hands or fists, legs, use of any object as a weapon.

Communicating any threats, explicit or implied, verbally or in writing, of any physical/psychological/ emotional harm to any individual at or connected with WNCCHS—even if the threat is expressed only through electronic means (e.g., social media).

Disregarding **any** policy, procedure, request, or instruction that authorized WNCCHS personnel deem necessary and appropriate to maintain safety, orderly operations, and a respectful environment.

Directing any obscene, foul, vulgar, or offensive language to any individual at WNCCHS.

Making degrading comments about anybody's race, religion, ethnicity, national origin, sex, sexual orientation, gender identity, disability, diagnoses, immigration status, English proficiency, literacy/educational level, or physical appearance (e.g., "body shaming). WNCCHS considers all such comments to be **hate speech and will not be tolerated.**

Invading or violating the privacy and confidentiality of any individual at WNCCHS by recording, reproducing, or disseminating the individual's image, voice, or identifying information (e.g., "tagging" and posting on Facebook) without the individual's explicit written consent.

Intentionally damaging or destroying others' property.

Patient Name (Printed): _____

Patient Signature (or Guardian): _____ **Date:** _____

Western North Carolina Community Health Services

WNCare SLIDING FEE APPLICATION

Patient's Last Name _____ Patient's First Name _____ Date of Birth _____ Social Security No. _____

INSTRUCTIONS: WNCare is our internal financial assistance program for patients of our health center. Eligibility is determined based only on household size and income. Participation is **optional**, but using the program can decrease your cost of all healthcare visits and pharmacy medications. Even patients with insurance coverage can use the program to possibly lower the co-pays and deductibles you have to pay. If you do not participate, you are expected to pay full price for all charges. Information taken with this application is **strictly confidential**.

NON-PARTICIPATION AGREEMENT

By signing, I confirm that I choose to NOT participate in the WNCare sliding fee program

Patient Name (Printed): _____

Patient Signature (or Guardian): _____ Date: _____

* INDICATES A REQUIRED FIELD DEMOGRAPHIC INFORMATION

*Do you speak English? YES ☐ NO ☐ *Do you need an interpreter? YES ☐ NO ☐ _____ Preferred Language?

*Refugee Status? YES ☐ NO ☐ _____ If yes, country of origin?

*Veteran Status? YES ☐ NO ☐

*Migrant Worker? YES ☐ NO ☐

*Public Housing? YES ☐ NO ☐

*Homeless? YES ☐ NO ☐

*Homeless Status Description? Not Homeless ☐ Homeless Shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Unknown ☐ Choose not to disclose ☐

_____ *Number of Federal income tax exemptions: _____ *Amount of annual adjusted gross income:

STATE OF EMERGENCY SIGNATURE CONSENT

I understand this information has been given to a WNCCHS Staff member during a phone consultation, and I authorize the staff member to sign the document on my behalf during a state of emergency (Example: Covid Pandemic) where I am incapable of participating in office at WNCCHS.

*YES ☐ NO ☐

CERTIFICATION: *The information on this form will be used to determine eligibility for a Federal assistance Program. Providing false or misleading information is a violation of Federal law. My signature below certifies all the information provided is accurate and true. My signature below also certifies that I received education about the Affordable Care Act and all of my questions were answered*.

Patient Name (Printed): _____

Patient Signature (or Guardian): _____ Date: _____ Staff Initials: _____

Staff Initials: _____

Western North Carolina Community Health Services

CONSENT FOR EVALUATION AND TREATMENT

Western North Carolina Community Health Services, Inc. (WNCCHS) is dedicated to providing quality primary care services to the community. Primary Care includes preventive, urgent, and chronic disease care for medical and behavioral health conditions/problems. This also includes laboratory tests (including HIV and urine drug screens), other diagnostic tests. I understand that I can decline HIV screening and other diagnostic testing.

Comprehensive and coordinated care may require your providers to involve other healthcare specialists as part of your care team. Members of your health care team will collaborate and share clinical information. Documentation by all care team providers, including behavioral health, will be stored in our electronic medical record.

I understand if I am 18 years of age or older, I may consent for all health services; otherwise my parent or legal guardian will need to consent to services. Be aware that, NC state law does allow those that are not yet 18 to consent to treatment without parental consent or notification when such treatment is related to sexual health, pregnancy, substance use and/or abuse, or mental health services. Please consult with your treatment provider if you are interested in providing your own consent.

Purpose of Document: The purpose of this document is to outline your rights and responsibilities as a patient of WNCCHS, as well as our rights and responsibilities to you. Please review this document very carefully and feel free to ask any questions or seek clarification from your WNCCHS provider about items contained within this document. Please sign this form to signify that you have read it in its entirety. You will receive a copy of this signed consent form.

Limits of Confidentiality: All information that you disclose to your WNCCHS provider during the course of treatment is confidential and will not be revealed without your written permission (or your parents' permission if you are under 18 years old) except for treatment, payment, or healthcare operations as permitted by law. Disclosure, may also be permitted or required by law when: (1) there is reasonable suspicion of child abuse, elder adult abuse and/or abuse of disabled adults; (2) there is a reasonable suspicion that you may present a danger of violence to others; and/or (3) there is a reasonable suspicion that you are likely to harm yourself. Disclosure may be required pursuant to a legal proceeding. If you have any questions about the limits of confidentiality, please discuss these concerns with behavioral health provider prior to signing this document.

HIPAA: The HIPAA Privacy Rule, a regulation developed by the U.S. Department of Health and Human Services, establishes a minimum level of privacy protection for health care information. The Privacy Rule establishes a patient's rights regarding the use and disclosure of his/her health care information. Please be aware that we will send information as requested by your insurance company in order to obtain payment. Your signature below indicates that you authorize WNCCHS to file for payment with your insurance company. Our Notice of Privacy Practices is available on our website (www.WNCCHS.org) or upon request.

By signing this form (parent or legal guardian signature, if required), I agree that I have read or had this form read and/or explained to me, that I understand it and that any questions I asked have been answered.

I hereby agree and consent to evaluation and treatment for myself and/or child(ren) as set forth above, including any studies or procedures that WNCCHS professional staff decide are necessary or appropriate. I may revoke my consent at a later time. If signing as parent or guardian, I hereby represent and warrant that I am legally empowered and entitled to make such decisions.

Patient Signature (or Guardian): _____ Date: _____

Staff Initials: _____